DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 438, 442, and 483

[CMS–3442–P]

RIN 0938–AV25

Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish minimum staffing standards for long-term care facilities, as part of the Biden-Harris Administration's Nursing Home Reform initiative to ensure safe and quality care in long-term care facilities. In addition, this rule proposes to require States to report the percent of Medicaid payments for certain Medicaid-covered institutional services that are spent on compensation for direct care workers and support staff.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by November 6, 2023.

ADDRESSES: In commenting, please refer to file code CMS–3442–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3442–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3442–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: The Clinical Standard Group's Long Term Care Team at *HealthandSafetyInquiries@cms.hhs.gov* for information related to the minimum staffing standards.

Anne Blackfield, (410) 786–8518, for information related to Medicaid institutional payment transparency reporting.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

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I. Executive Summary

A. Purpose

This proposed rule would establish minimum staffing standards to address ongoing safety and quality concerns for the 1.4 million [1] residents receiving care in Medicare and Medicaid certified Long-Term Care (LTC) facilities. On February 28, 2022, President Biden announced that CMS would propose minimum staffing standards that nursing homes must meet, based in part on evidence from a new research study that will focus on the level and type of staffing needed to ensure safe and quality care.[2] In addition, on April 18, 2023, President Biden issued ''Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers'',[3] which directs the Secretary of HHS to consider actions to encourage LTC facilities to reduce nursing staff turnover that is associated with improving safety and quality of care.[4] [5]

These safety and quality concerns stem, at least in part, from chronic understaffing in LTC facilities, and are particularly associated with insufficient numbers of registered nurses (RNs) and nurse aides (NAs), as evidenced from, *inter alia,* a review of data collected since 2016 and lessons learned during the COVID–19 Public Health Emergency (PHE). Numerous studies, including our new research study as well as existing literature, have shown that staffing levels are closely correlated with the quality of care that LTC facility residents receive, and with improved health outcomes. The minimum staffing standards would also provide staff in LTC facilities the support they need to safely care for residents, help prevent staff—burnout, thereby reducing staff turnover, which can lead to improved safety and quality for residents and staff. This proposed rule would also promote public transparency related to the percent of Medicaid payments for certain institutional services that are spent on compensation to direct care workers and support staff.

B. Summary of Major Provisions

We are proposing to update the Federal participation ''Requirements for Medicare and Medicaid Long Term Care Facilities'' minimum staffing standards (''LTC requirements''). The updates to

[1] *https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/cms-program-statistics-medicare-skilled-nursing-facility.*

[2] *https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.*

[3] *Executive Order on Increasing Access to High Quality Care and Supporting Caregivers.* White House. Accessed at *https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/.* Published on April 18, 2023. Accessed on April 19, 2023.

[4] Zheng, Q, Williams, CS, Shulman, ET, White, AJ. Association between staff turnover and nursing home quality—evidence from payroll-based journal data. *J Am Geriatr Soc.* 2022; 70(9): 2508–2516. doi:10.1111/jgs.17843.

[5] Castle, Nicholas G, and John Engberg. ''Staff turnover and quality of care in nursing homes.'' *Medical care* vol. 43,6 (2005): 616–26. doi:10.1097/01.mlr.0000163661.67170.b9.

the LTC requirements proposed in this rule would be used to survey facilities for compliance and enforced as part of CMS's existing survey, certification, and enforcement process for LTC facilities. In addition, consistent with the President's strategic plan, we also intend to display our determinations of facility compliance with the minimum staffing standards on Care Compare. We welcome comments on the most appropriate approach for doing so.

We are proposing to establish Federal minimum nurse staffing standards for a number of reasons, including the growing body of evidence demonstrating the importance of staffing to resident health and safety, continued insufficient staffing, non-compliance by a subset of facilities, the need to reduce variability in the minimum floor for nurse-to-resident ratios across States by creating a consistent floor, and, most importantly, to reduce the risk of residents receiving unsafe and low-quality care.

The proposed regulatory updates are based on evidence we collected using a multifaceted approach, which included conducting a new nursing home staffing study, gathering feedback during listening sessions, considering more than 3,000 comments received from the Fiscal Year 2023 Skilled Nursing Facility Prospective Payment System proposed rule (FY2023 SNF PPS) request for information (RFI), assessing Payroll-Based Journal (PBJ) System data on nursing home staffing, and reviewing the existing literature.

Specifically, we propose to revise § 483.35(b) to require an RN to be on site 24 hours per day and 7 days per week to provide skilled nursing care to all residents in accordance with resident care plans. We also propose individual minimum staffing type standards, based on case-mix adjusted data for RNs and NAs, to supplement the existing ''Nursing Services'' requirements at 42 CFR 483.35(a)(1)(i) and (ii) to specify that facilities must provide, at a minimum, 0.55 RN hours per resident day (HPRD) and 2.45 NA HPRD. We note that while the 0.55 and 2.45 HPRD standards were developed using case-mix adjusted data sources, the standards themselves will be implemented and enforced independent of a facility's case-mix. In other words, facilities must meet the 0.55 RN and 2.45 NA HPRD standards, at a minimum, regardless of the individual facility's patient case-mix. RN and NA staffing can never be lower than these proposed minimum standards, and if the acuity needs of residents in a facility require a higher level of care, a higher RN and NA staffing level will also be required. CMS is also seeking comments on whether in addition to the 0.55 RN and 2.45 NA HPRD standards, a minimum total nurse staffing standard, discussed later in the rule, should also be required. For compliance, hours per resident day (HPRD) is defined as staffing hours per resident per day which is the total number of hours worked by each type of staff divided by the total number of residents as calculated by the CMS. As further described below, the proposed minimum staffing standard is supported by literature evidence, analysis of staffing data and health outcomes, discussions with residents, staff, and industry [6] and other factors.

We note that each of the minimum staffing requirements independently supports resident health and safety. Therefore, compliance with the 24/7 RN requirement does not imply compliance with the minimum 0.55 RN HPRD and 2.45 NA HPRD requirements or vice versa. Specifically, as discussed elsewhere in this rule, the presence of an RN in a LTC facility on a 24-hour basis improves overall quality of care. Similarly, but separately, a minimum number of RN and NA hours per resident per day improve overall quality of care. Both independently and collaboratively, these requirements would support compliance with statutory mandates to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care.

As noted elsewhere, this proposal is informed by multiple sources of information, including the 2022 Nursing Home Staffing Study, more than 3,000 public comment submissions, academic and other literature, PBJ System data, and detailed listening sessions with residents and their families, workers, health care providers, and advocacy groups. We recognize that some of the materials we have relied upon offer support for a higher minimum HPRD standard. For several reasons discussed later in this proposed rule, including the importance of setting achievable staffing targets as the long-term care sector recovers from the effects of the COVID–19 pandemic and the desire to preserve resident access to care as the sector expands hiring to meet staffing standards, we are proposing a set of policies that balance the urgent need to improve resident safety and quality of care alongside these practical considerations. The policies include minimum HPRD standards for direct care by nursing staff, required access to an RN 24 hours per day 7 days per week, and enhanced facility staffing assessments.

For example, the 2022 Nursing Home Staffing Study found that a total nurse staffing level of 3.67 or 3.88 HPRD was linked with additional facilities improving quality and safety relative to current low performers, and that total nurse staffing levels between 3.8 HPRD and 4.6 HPRD (including 1.4 licensed nurse HPRD) were linked with reductions in the amount of delayed or omitted clinical care. Our proposal squares these associations between higher HPRD nurse staffing levels and better care outcomes with the goal of establishing implementable minimum standards that can substantially improve quality and safety at all LTC facilities in the near-term. We also considered variation and contradiction between different information sources, including the 2022 Nursing Home Staffing Study, namely regarding the benefits of a staffing standard inclusive of or specific to LPN/LVNs. We further considered the benefits of a requirement for 24/7 on-site RN staffing and strengthened facility staffing assessments, which under this proposed rule apply independently of the HPRD requirements.

The resulting, evidence-based proposal appropriately prioritizes quality and safety of care gains from establishing minimum standards for RNs and NAs, with a particular emphasis on the direct care delivered at the bedside by NAs, and effective implementation of these new requirements. As noted elsewhere, if finalized, these new required floors would increase staffing in more than 75 percent of nursing facilities nationwide, and the proposed NA and RN HPRD requirements exceed those of nearly all States. We remain committed to continued examination of staffing thresholds, including careful work to review quality and safety data resulting from initial implementation of finalized policies, and robust public engagement. Should subsequent data indicate that additional increases to staffing minimums would be warranted and feasible, we anticipate that we will revisit the minimum staffing standards to shift them toward the higher ranges supported by the evidence, such as those described above, with continued consideration of all relevant factors.

We also propose to revise the existing Facility Assessment requirements at § 483.70(e) by moving the provisions to a standalone section and modifying the

[6] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

requirements to ensure that facilities have an efficient process for consistently assessing and documenting the necessary resources and staff that the facility requires to provide ongoing care for its population that is based on the specific needs of its residents.

We are proposing to stagger the implementation dates of these requirements sufficiently to allow facilities the time needed to prepare and be in compliance with the new requirements. Specifically, we propose that the RN on site, 24 hours per day, for 7 days a week would take effect 2 years after publication of the final rule; and we propose that the individual minimum standards of 0.55 HPRD for RNs and 2.45 HPRD for NAs would take effect 3 years after publication of the final rule. Under the proposal facilities in rural areas would be required to meet the proposed RN on site 24 hours per day, for 7 days a week, 3 years after publication of the final rule; and the proposed minimum standards of 0.55 HPRD for RNs and 2.45 HPRD for NAs would take effect 5 years after publication of the final rule.

Exemption from the proposed minimum standards of 0.55 HPRD for RNs and 2.45 HPRD for NAs would be available only in limited circumstances, where all four of the following criteria are met. The four exemption criteria are: (1) where workforce is unavailable, or the facility is at least 20 miles from another long-term care facility, as determined by CMS; (2) the facility is making a good faith effort to hire and retain staff; (3) the facility provides documentation of its financial commitment to staffing; and (4) the facility has not failed to submit PBJ data in accordance with re-designated 483.70(p), is not a Special Focus Facility (SFF); has not been cited for widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm, as determined by CMS; and has not been cited at the ''immediate jeopardy'' level of severity with respect to insufficient staffing within the 12 months preceding the survey during which the facility's non-compliance is identified.

If finalized, enforcement actions, also called remedies, would be taken against LTC facilities that are not in compliance with these Federal participation requirements. The remedies CMS may impose include, but are not be limited to, the termination of the provider agreement, denial of payment for all Medicare and/or Medicaid individuals by CMS, and/or civil money penalties.

We are also proposing new regulations at 42 CFR 442.43 (with a cross-reference at 42 CFR 438.82) that would require that State Medicaid agencies report on the percent of payments for Medicaid-covered services in nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that are spent on compensation for direct care workers and support staff. This proposal is designed to inform efforts to address the link between sufficient payments being received by the institutional direct care and support staff workforce and access to and, ultimately, the quality of services received by Medicaid beneficiaries. Taken together, we believe that these proposals will improve safety and quality of care for residents in Medicare and Medicaid certified LTC facilities and Medicaid certified ICF/IIDs.

C. Summary of Cost and Benefits

TABLE 1—COST AND BENEFITS

Provision description	Total transfers/costs
Comprehensive Staffing Requirement for LTC Facilities	Without accounting for any exemptions, we estimate that the overall economic impact for the proposed minimum staffing requirements for LTC facilities (that is, collection of information costs and compliance with the 24/7 RN, facility assessment, and minimum 0.55 RN and 2.45 NA HPRD requirements), which includes staggered implementation of the requirements, would result in an estimated cost of approximately for $32 million in year 1; $246 million in year 2; $4 billion in year 3; with costs increasing to $5.7 billion by year 10. We estimate the total cost over 10 years will be $40.6 billion, which was derived from *FY 2021 Part V* of the Medicare Cost Report. LTC facilities would be expected to bear the burden of these costs, unless payors increase rates to cover cost. Quantified benefits include but are not limited to, increased community discharges, reduced hospitalizations, and emergency department visits, with a minimum estimated savings of gross costs of $318 million per year for Medicare starting in year 3. Various categories of other important but hard to quantify benefits include reduced staff burnout and turnover, and increased safety and quality of care for LTC residents. Lack of quantification is also noteworthy as regards key categories of costs.
Medicaid Institutional Payment Transparency Reporting	The overall economic impact for the proposed reporting requirement is a one time cost of $38 million and ongoing annual costs of $18 million per year.

II. Minimum Staffing Standards for Long-Term Care Facilities

A. Background

1. Statutory Authority and Regulatory Requirements for Direct Care Nurse Staffing in Long-Term-Care (LTC) Facilities

Sections 1819 and 1919 of the Social Security Act (the Act) set out regulatory requirements for Medicare and Medicaid long-term care facilities, respectively. Specific statutory language at sections 1819(d)(4)(B) and 1919(d)(4)(B) of the Act permit the Secretary of the Department of Health and Human Services (the Secretary) to establish any additional requirements relating to the health, safety, and well-being [7] of residents in skilled nursing facilities (SNF) and nursing facilities (NF), as the Secretary finds necessary. This provision and other statutory authorities set out in section 1819 and

[7] Section 1819(d)(4)(B) of the Act contains the word ''well-being'', which does not appear in section 1919(d)(4)(B). We do not interpret the presence of this word as requiring separate regulatory treatment of Medicare and Medicaid long term care facilities.

1919 of the Act provide CMS with the authority to issue a regulation revising the existing requirements and to mandate a staffing minimum for nursing care. Under sections 1866 and 1902 of the Act, providers of services in Long Term Care (LTC) facilities seeking to participate in the Medicare or Medicaid program, or both, must enter into an agreement with the Secretary or the State Medicaid agency, respectively. LTC facilities seeking to be Medicare or Medicaid providers of services must be certified as meeting Federal participation requirements. These Federal participation requirements are the basis for survey activities in LTC facilities for ensuring residents' minimum health and safety requirements are met and maintained, to receive payment and remain in the Medicare or Medicaid program or both. LTC facilities include SNFs for Medicare and NFs for Medicaid. The Federal participation requirements for SNFs, NFs, or dually certified facilities, are codified in the implementing regulations at 42 CFR part 483, subpart B. In addition to those provisions, sections 1819(b)(1)(A) and 1919(b)(1)(A) of the Act require that a SNF or NF must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the safety and quality of life of each resident. Section 1819(b)(4)(C)(i) of the Act requires that a SNF must provide 24-hour licensed nursing services, sufficient to meet the nursing needs of its residents, and must use the services of a registered professional nurse at least 8 consecutive hours a day. These provisions are largely paralleled at section 1919(b)(4)(C)(i) of the Act for NFs. Sections 1819(f)(1) and 1919 (f)(1) of the Act require that the Secretary assure that requirements which govern the provision of care in skilled nursing facilities under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

In addition, sections 1819(b)(2) and 1919(b)(2) of the Act require that a SNF or NF provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care. The plan of care must describe the medical, nursing, and psychosocial needs of the resident and how the needs will be met. The plan of care is developed with the resident or resident's family or legal representative, and by a team which includes the resident's attending physician and an RN with responsibility for the resident. The plan of care should be periodically reviewed and revised by the team after required assessments. Sections 1819(b)(3) and 1919(b)(3) of the Act require that a SNF or NF conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Assessments are required to be conducted or coordinated by a registered nurse at specified frequencies.

The participation requirements for LTC facilities (Federal requirements) are set forth at §§ 483.1 through 483.95. In general, the health and safety standards for LTC facilities address facility administration, resident rights, care planning, quality assessment, performance improvement, services provided, emergency preparedness, as well as staffing requirements. Federal requirements state that LTC facilities must use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week (§ 483.35(b)(1)), and must provide the services of ''sufficient numbers'' of licensed nurses and other nursing personnel, which includes but is not limited to nurse aides (NAs), 24 hours a day to provide nursing care to all residents in accordance with the resident care plans (§ 483.35(a)(1)). The LTC facility must also designate an RN to serve as the director of nursing (DON) on a full-time basis (§ 483.35(b)(2)).

While these Federal requirements do specify a specific number of hours that these licensed nurses and other nursing personnel must be available, there is no requirement that those hours be specifically dedicated to direct resident care. With respect to staffing requirements specific to individual residents, such as RN staffing levels per resident, Federal regulations currently require that facilities provide staff sufficient to ''assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident''. Facilities should determine whether this is met through ''resident assessments and individual plans of care and considering the number, acuity, and diagnoses or the facility's resident population'' (§§ 483.35 and 483.70(e)).

2. The Need for a Minimum Nurse Staffing Requirement in LTC Facilities

On October 4, 2016, we issued a final rule titled, ''Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities'' (81 FR 68688). This final rule significantly revised the list of requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs. Prior to the final rule, LTC facilities' requirements had not been comprehensively reviewed and updated since 1991 (56 FR 48826, September 26, 1991), despite substantial changes in service delivery in this setting. The final rule included revisions that reflect advances in the theory and practice of LTC service delivery and safety. The various revisions sought to achieve broad-based improvements in the quality of care provided in LTC facilities and in resident safety. As part of this 2016 final rule, we revised LTC facilities requirements to include competency requirements for determining the sufficiency of nursing staff, based on a facility assessment requirement that LTC facilities must conduct to determine what resources are needed to competently care for their residents during both day-to-day operations and emergencies. In the 2015 proposed rule, we included a robust discussion regarding the long-standing interest in increasing the required hours of nurse staffing per day and the various literature surrounding the issue of minimum nurse staffing standards in LTC facilities (see 80 FR 42199). In the 2016 final rule, we also included a discussion of the feedback received regarding our competency-based staffing approach (see 81 FR 68688). At the time, we highlighted the importance of establishing national staffing standards to promote safe, high- quality care for residents in LTC facilities and our desire to further explore potential options, however we noted that we needed additional evidence before pursuing potential requirements. We acknowledged that additional literature evidence along with data from sources such as Payroll Based Journal (PBJ) System would be helpful in determining if and what staffing levels should be established as minimum staffing standards to improve safety and the quality of care.[8] Additionally, the availability of PBJ System data is essential to adequately enforcing oversight of minimum staffing standards. Since issuing the 2016 final rule and establishing a competency-based approach to staffing in the list of LTC requirements, we have collected several years of mandated PBJ System data and new evidence from the literature.

[8] *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.*

Additionally, as a part of the FY 2023 Skilled Nursing Facility Prospective Payment System Proposed Rule Request for Information (FY 2023 SNF PPS RFI) discussed later in this proposed rule, commenters provided examples of ongoing quality and safety concerns within understaffed LTC facilities. These included, but are not limited to, residents going entire shifts without receiving toileting or days without bathing assistance, increases in falls, residents not receiving basic feeding or changing services, and even abuse in cases where no one was watching. The 2022 Nursing Home Staffing Study (also discussed later in this proposed rule) corroborated these comments and identified that basic care tasks, such as bathing, toileting, and mobility assistance, are often delayed when LTC facilities are understaffed. Interviews with various nurse staff highlighted ongoing concerns that care is often rushed, including for high-acuity residents, which can often lead to errors or safety issues.

The COVID–19 Public Health Emergency (PHE) highlighted and exacerbated the long-standing concerns with inadequate staffing in LTC facilities. However, the COVID–19 PHE also yielded evidence that appropriate staffing made a difference as a part of the overall response to the COVID–19 PHE in LTC facilities. The Centers for Disease Control and Prevention (CDC) noted that nursing home residents were at high risk for infection, serious illness, and death from the COVID–19 infection and Medicare beneficiaries were disproportionately impacted by the COVID–19 infection, with 76 percent of COVID–19 related deaths attributed to the people aged 65 years and older by the end of 2021.[9] One study looking at 4,254 LTC facilities across eight States found that there were fewer COVID–19 cases in LTC facilities with four or five stars for nurse staffing in the Five Star Quality Rating System than in counterpart facilities with one to three stars for staffing.[10] These findings suggest that LTC facilities with low nurse staffing levels may have been more susceptible to the spread of the COVID–19 infection. Findings from a recent 2020 study involving all 215 nursing homes in Connecticut revealed that a 20-minute increase in RN time spent providing direct care to residents was associated with 22 percent fewer confirmed cases of COVID–19 and 26 percent fewer COVID–19 related deaths.[11] These findings suggest that there is a positive relationship between the hours of direct care that RNs provide and infection transmission in LTC facilities.

Workforce challenges have contributed to understaffing and nurse burnout. The lack of adequate staffing impedes staff members' ability to devote adequate time and attention to each resident. One study looked at the impact of nurse burnout on organization and position turnover. Findings indicated that 54 percent of the nurses sampled suffered from moderate burnout and the impact of burnout on organizational turnover was significant.[12] While workforce challenges have existed for years, and have many contributing factors, interested parties have reported that the COVID–19 PHE exacerbated the problem as many long-term care facilities experienced high worker turnover. Potential factors contributing to this turnover include higher rates of worker reported-stress; an inability of some workers to return to their positions held prior to the pandemic (for instance, due to difficulty accessing child care or concerns about contracting the COVID–19 infection for people with higher risk of severe illness); high rates of mortality among long-term- care workers; and lower pay and job quality in long-term care settings relative to others, such as more competitive wage increases in retail and other industry jobs that tend to draw from the same pool of workers.[13] [14] [15] Although the COVID–19 PHE has officially ended, the long-term care nursing workforce has been slower to recover than the nursing workforce in other healthcare settings, although it has steadily increased over the past year and a half.[16] [17] Demand for direct care workers is also expected to continue rising due to the growing needs of the aging population.[18] [19]

The studies discussed in this section, corroborated by public comment submissions, input provided through listening sessions, and the 2022 Nursing Home Staffing Study, demonstrate the consequences of understaffing on resident health and safety. Yet, ongoing insufficient staffing as well as the widespread variability in existing minimum staffing standards across the United States (for example, 38 States and the District of Columbia have minimum nursing staffing standards; however, there are significant variations in their requirements) highlights the need for national minimum staffing standards for direct care in LTC facilities.

Chronic understaffing continues in LTC facilities, and evidence demonstrates the benefits of increased nurse staffing in these facilities. For example, a report by the Office of the Inspector General (OIG) highlighted that in 2018, roughly 7 percent of nursing homes failed to provide 8 hours per day of RN staffing on at least 30 total days during the year.[20] Some studies have demonstrated that increased staffing levels were specifically beneficial to vulnerable subpopulations in nursing homes, such as residents with dementia or Alzheimer's disease. One cross sectional study of long-stay residents with Alzheimer's disease and related dementias found that residents in

[9] March 2022 Report to the Congress: Medicare Payment Policy, MEDPAC.

[10] Figueroa JF, Wadhera RK, Papanicolas I, et al. Association of Nursing Home Ratings on Health Inspections, Quality of Care, and Nurse Staffing With COVID–19 Cases. JAMA. 2020;324(11):1103–1105. doi:10.1001/jama.2020.14709.

[11] *https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16689.*

[12] Kelly LA, Gee PM, Butler RJ. Impact of nurse burnout on organizational and position turnover. Nurs Outlook. 2021 Jan-Feb;69(1):96–102. doi: 10.1016/j.outlook.2020.06.008. Epub 2020 Oct 4. PMID: 33023759; PMCID: PMC7532952.

[13] Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI. Accessed at *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[14] Gasdaska, A., Segelman, M., Porter, K.A., Huber, B., Feng, Z., Barch, D., Squillace, M., Dey, J., & Oliveira, I. Nursing Home Staffing Disparities were Exacerbated during the COVID–19 Pandemic in 2020 (Research Brief). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. September 12, 2022. Accessed at *https://aspe.hhs.gov/sites/default/files/documents/e37945b7d88efb005839a876660a59fb/nh-staffing-disparities-brief.pdf.*

[15] Ochieng, N., Chidambaram, P., Musumeci, M. Nursing Facility Staffing Shortages During the COVID–19 Pandemic. Apr 04, 2022. Kaiser Family Foundation. Accessed at *https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/.*

[16] Refer, for example, to a report from the Kaiser Family Foundation indicating that as of March 20, 2022, 28% of nursing facilities reported a staffing shortage, as reported in Ochieng, N., Chidambaram, P., Musumeci, M. Nursing Facility Staffing Shortages During the COVID–19 Pandemic. Apr 04, 2022. Kaiser Family Foundation. Accessed at *https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic.*

[17] *https://data.bls.gov/timeseries/CES6562300001?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true.*

[18] Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[19] Centers for Medicare & Medicaid Services. November 2020. Long-Term Services and Supports Rebalancing Toolkit. Accessed at *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.*

[20] Office of Inspector General (OIG), Some Nursing Homes' Reported Staffing Levels in 2018 Raise Concerns; Consumer Transparency Could Be Increased, OEI–04–18–00451, August 2020. *https://oig.hhs.gov/oei/reports/oei-04-18-00450.asp.*

nursing homes that had higher licensed nurse staffing levels had better end-of-life care and were less likely to experience potentially avoidable hospitalizations.[21] Yet, the literature evidence suggests that staffing levels within facilities across the United States vary considerably, with less staffed facilities more likely to be for—profit, larger, rural, and have a higher share of Medicaid residents.

Finally, multiple studies have shown that nursing home quality is generally lower in LTC facilities that serve high proportions of minority residents.[22] [23] [24] Facilities that have a higher proportion of minority residents tend to have limited clinical and financial resources, low nurse staffing levels, and a high number of care deficiency citations.[25] [26] Furthermore, disparities in safety and quality care exist between LTC facilities with a high number of Medicaid residents and LTC facilities that have a high number of Medicare residents.[27] These disparities can contribute to differences in quality across facilities' sites.[28]

As such, we believe that national minimum staffing standards in LTC facilities and the adoption of a 24/7 RN and enhanced facility assessment requirements (as discussed later in this proposed rule), will help to advance equitable, safe, and quality care for all residents. Specifically, we propose individual minimum nurse staffing standards of 0.55 hours per resident day (HPRD) for RNs and 2.45 HPRD for NAs, that were developed using case-mix adjusted data sources. There were several considerations that helped us arrive at these proposed standards (discussed in detail later in this proposed rule). First, the evidence and findings from the 2022 Nursing Home Staffing Study demonstrated that there was a statistically significant difference in safety and quality care at 0.45 HPRD for RNs and higher including 0.55 HPRD; there was a statistically significant difference in safety and quality care at 2.45 HPRD and higher for NAs. Second, we evaluated existing State requirements and note that the proposed RN requirement of 0.55 HPRD is higher than every State and only lower than the District of Columbia (DC) based on September 2022 data. Third, we aimed to strike an appropriate balance between cost and benefit that would yield the strongest improvements in quality and safety for residents. We are not proposing minimum staffing standards based on HPRD for licensed nurses, that is, RNs plus LPN/LVNs, nor for total nurse staffing, that is, RNs, LPN/LVNs, and NAs because of evidence in the literature described below.

This proposed policy is based on statistical evidence from clinical settings which suggests that more positive clinical outcomes are associated with increasing the number of RNs and NAs. We are not setting a minimum staffing standard for LPN/LVNs. In addition, as noted in the next section, it has been reported in the literature that LPN/LVNs may find themselves practicing outside their scope of practice when there is not sufficient RN staffing in a facility to provide supervision. This is concerning because LPN/LVNs require an RN or a physician's supervision to practice. Furthermore, total licensed nurse staffing standards may ensure adequate levels of licensed nurse staffing and allow nursing homes the flexibility to substitute nurse type for example LPN/LVNs for RNs, or NAs for LPN/LVNs, but may result in compromising the safety and quality of care. Multiple studies have found no evidence of a consistent relationship of quality and safety with LPN staffing.[29] First, literature evidence suggests that there is a negative correlation between LPN and RN staffing, indicating that nursing homes with higher LPN staffing levels tend to have lower RN staffing levels.[30] Second, the 2022 Nursing Home Staffing Study did not demonstrate an association between LPN/LVNs' HPRD, at any level, and safe and quality care.[31]

Many studies indicate that consistent, adequate nurse staffing is correlated with resident health and safety, but we seek additional information to make fully informed policy decisions. We welcome input from interested parties on the considerations and proposals discussed in this rule, and other comments that may be relevant. We encourage commenters to submit evidence and data to support any recommendations to the extent possible. We continue to seek additional information that supports our efforts for improving the safety and quality of care for residents within LTC facilities, including feedback on how to improve care transitions and discharge planning, such as information about and assistance with programs that assist with community placements.

We are soliciting comments and recommendations in this area and have also included specific information requests that are embedded throughout this rule regarding certain proposals. We seek this information in anticipation that additional comments and recommendations will assist us in ensuring that we finalize appropriate minimum staffing standards to ensure the health and safety of residents and provide staff the support they need to care for residents while also considering the limited resources including the local supply of RNs and NAs, that may exist as the long-term care sector recovers from the COVID–19 PHE and an increased demand due to a growing older population.

3. CMS Actions and Key Considerations To Inform Mandatory Minimum Staffing Standards

In February 2022, President Biden announced a comprehensive set of reforms aimed at improving the safety and quality of care within the nation's nursing homes. One key initiative within the Biden-Harris Administration's strategy is to establish a minimum nursing home staffing requirement for LTC facilities participating in Medicare and Medicaid.[32] Establishing minimum staffing standards improves the likelihood that all nursing home residents are provided safe, high-quality

[21] Jessica Orth, Yue Li, Adam Simning, Sheryl Zimmerman, Helena Temkin-Greener, End-of-Life Care among Nursing Home Residents with Dementia Varies by Nursing Home and Market Characteristics Journal of the American Medical Directors Association, Volume 22, Issue 2, 2021, Pages 320–328.e4, ISSN 1525–8610, *https://doi.org/10.1016/j.jamda.2020.06.021.*

[22] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805666/.*

[23] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108174/.*

[24] *https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.12079.*

[25] *https://www.jamda.com/article/S1525-8610(21)00243-7/fulltext.*

[26] *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0094.*

[27] Mor, Vincent et al. ''Driven to tiers: socioeconomic and racial disparities in the quality of nursing home care.'' The Milbank quarterly vol. 82,2 (2004): 227–56. doi:10.1111/j.0887–378X.2004.00309.x.

[28] *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0094.*

[29] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[30] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[31] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[32] *https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.*

care, and that workers have the support they need to provide high-quality care.

To help inform our efforts in establishing consistent and broadly applicable national minimum staffing standards, we launched a multi-faceted approach aimed at determining the minimum level and type of staffing needed to enable safe and quality care in LTC facilities. This effort included issuing the FY2023 SNF PPS RFI,[33] hosting listening sessions with various interested parties, and conducting a 2022 Nursing Home Staffing Study, which builds on existing evidence and several research studies using multiple data sources. In addition to launching our multi-faceted approach, we considered how any potential minimum staffing standards affect other CMS programs and/or initiatives as well as the enforceability of such standards. Our strategic approach and considerations are discussed later in this section.

a. Request for Information in the FY 2023 Skilled Nursing Facility Prospective Payment System Proposed Rule (FY 2023 SNF PPS RFI)

We published the FY 2023 SNF PPS RFI in April 2022, soliciting public comments on minimum staffing standards. In response to the FY 2023 SNF PPS RFI, we received over 3,000 comments from a variety of parties interested in addressing LTC facilities' issues including advocacy groups, long-term care ombudsmen, industry associations (providers), labor unions and organizations, nursing home residents, staff and administrators, industry experts, researchers, family members, and caregivers of residents in LTC facilities.

Notably, industry associations and resident advocates expressed divergent views on the establishment of minimum staffing standards. Resident advocacy groups and family members of residents were strongly supportive of establishing minimum staffing standards, while industry and provider groups expressed significant concern and opposition to such standards.

Commenters supporting the establishment of minimum staffing standards voiced safety concerns regarding residents not receiving adequate care due to chronic understaffing in facilities. For example, residents going entire shifts without receiving toileting assistance, which can lead to an increase in falls or the development or worsening of pressure ulcers. Commenters noted that NAs barely have time to get each resident dressed, fed, and bathed; that residents lie for hours in wet and soiled diapers; that residents who need help to eat struggle to feed themselves; and that residents suffer abuse from staff and other residents because no one is watching. Commenters also shared stories of residents wearing the same outfit for a week without a change of clothing or a shower. Commenters highlighted the contribution of facility staff and attributed the lack of quality care to insufficient staffing levels.

Commenters also offered recommendations for implementing minimum staffing standards including staffing with a RN on every shift. Some commenters suggested that CMS focus on implementing an acuity (that is, the medical complexity and needs of a resident) staffing model per shift as part of any minimum staffing standards. Others recommended that minimum staffing standards be established for residents with the lowest care needs, assessed using the Minimum Data Set (MDS) 3.0 assessment forms, citing concerns that acuity-based minimum standards will be more susceptible to gaming around composition of the patient population (that is, avoiding taking on residents with more complex medical needs).

Concerns raised by the local ombudsmen in the 2020 OIG Report on staffing levels echoed those raised by commenters. Some of the concerns identified in the OIG Report as a result of understaffing include residents' call lights going unanswered, medication errors, untreated wounds, and inadequate bathing, including residents going a week without a shower. The ombudsmen also focused on problems related to weekend staffing below required levels, resulting in resident falls and altercations between residents; the ombudsmen attributed such outcomes to facilities' inadequate leadership, as well as insufficient numbers of NAs.[34] This information supports what was shared with us during the listening sessions as well as during the public comment period on the FY 2023 SNF PPS RFI.

Commenters also provided information on several resident and facility factors for consideration when assessing a facility's ability to meet any mandated staffing standards, including whether the facility has a high Medicaid census, high bed count, for-profit ownership, high SNF competition within the same county, high community poverty rates, low Medicare census, and for staffing, availability of RNs specifically. Other commenters stated that resident acuity should be a primary determinant in establishing minimum staffing standards, noting that CMS pays nursing homes based on resident acuity level.

We also received comments on factors impacting facilities' ability to recruit and retain staff, with most commenters in support of creating avenues for competitive wages for nursing home staff to address issues of recruitment and retention. Other commenters, however, suggested that year-over-year reductions in skilled nursing facility payments complicate facilities' ability to increase staff wages and benefits.

Finally, we received differing comments on the study design, payment, and cost impacts of establishing minimum staffing standards. Some commenters indicated that there is variability in Medicaid labor reimbursement amounts and many States' Medicaid rates do not keep up with rising labor costs. Others, however, noted that most facilities have adequate resources to increase their staffing levels without additional Medicaid resources, and cited a recent study that suggests that most major publicly traded nursing home companies were highly profitable, even during the COVID–19 PHE. Commenters provided robust feedback on the study design and method for implementing nurse staffing standards, while others noted that resident acuity could change on a daily basis and recommended that CMS establish benchmarks rather than absolute values in staffing standards. Other commenters recommended using both minimum nurse HPRD and nurse to resident ratios.

Additionally, we note that several members of Congress have provided input regarding the establishment of minimum staffing standards. While some Members of Congress have expressed concern that requiring minimum staffing standards could create access issues for rural communities, other Members of Congress have expressed support for establishing minimum staffing

[33] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels. A Proposed Rule by the Centers for Medicare & Medicaid Services on 04/15/2022 *https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.*

[34] Office of Inspector General Data Brief (August, 2020) Some Nursing Homes' Reported Staffing Levels in 2018 Raise Concerns; Consumer Transparency Could Be Increased. OEI–04–18–00450. *https://oig.hhs.gov/oei/reports/OEI-04-18-00450.pdf.*

standards for LTC facilities.[35] We appreciate the thoughtful feedback from commenters and have considered the varying feedback that we received to inform the staffing study design and proposal for minimum staffing standards discussed in this rule.

b. The 2022 Nursing Home Staffing Study [36]

The CMS commissioned a nursing home staffing study in 2001, entitled ''Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes'',[37] commonly referred to as the 2001 CMS Staffing Study, that focused on two empirical analyses related to the link between staffing and quality: (1) whether there is a nurse staffing ratio above which no additional improvements in quality are observed, and (2) what nurse staffing thresholds are minimally necessary to provide care processes consistent with the Omnibus Budget Reconciliation Act (OBRA) of 1987 optimal standards and related regulations.

The study findings identified nursing home staffing thresholds beyond which additional staff did not lead to significant further improvements in care. These staffing levels, expressed in HPRD, varied by outcomes—short-stay or -long-stay- quality measures, by nurse staff type, and by level of nurse staffing. Depending on the nature of the nursing home population (case-mix), these thresholds ranged between: 0.55 to 0.75 HPRD for RNs; 1.15 to 1.30 HPRD for licensed nurses (RNs and LPN/LVNs); and 2.4 to 2.8 HPRD for NAs. The 2001 study also reported that ''*[m]inimum* staffing levels *at any level up* to *these thresholds are associated with incremental quality* improvements, *with the greatest benefits as these thresholds are approached*.'' In other words, 4.1 HPRD was the highest HPRD of combined NAs and licensed staff (RNs/LPN/LVN) for long-stay measures beyond which no further improvement in safety and quality was observed. The 4.1 HPRD drawn from the 2001 Study is commonly misinterpreted as the minimum total nurse staffing that is needed to protect resident health and safety.

The CMS also commissioned a simulation analysis (''time motion study'') on NA time expended for providing five key care processes,[38] in addition to routine care, to determine an HPRD level for NAs to provide optimal nursing care. The study findings suggest that the NA HPRD level ranged between 2.8 (low workload facility) and 3.2 HPRD (high workload facility) for NAs only, depending on the NA workload requirements which was based on the nursing home resident population.

Given the growing body of evidence demonstrating the importance of staffing to resident health and safety, the continued insufficient staffing, and variability in nurse-to-resident ratios across States, creating a consistent floor will reduce the risk of residents receiving unsafe and low-quality care. In 2022, given the age of the 2001 study and the persistent chronic nurse understaffing linked to poor safety and quality care, which was exacerbated by the COVID–19 PHE, we commissioned a new nursing home study that focused on a non-empirical analysis and four empirical analyses to develop minimum staffing standards using case-mix adjusted data sources, as well as staffing types and levels for improving safety and quality care in nursing homes.

These non-empirical and empirical analyses, also known as study tasks, included a systematic literature review, qualitative analysis of data collected using interviews and surveys conducted during scheduled site visits, an observation study (''similar to the time motion study'') followed by simulation modeling analysis for licensed nurses (RNs and LPN/LVNs), quantitative analyses which included descriptive and impact analyses, and cost analyses. The key takeaways from the multifaceted approach are:

- Recent literature as well as testimonials from nursing home staff, residents, and family members underscore the relationship between staffing and care quality; however, there is no clear, consistent, and universal methodology for setting specific minimum staffing standards, as evidenced by the varying current standards across certain States.
- Nurse staffing levels vary considerably nationwide by LTC facilities' characteristics, such as location, size, and profit status and States. Thirty-eight States and the District of Columbia have minimum staffing standards, which vary considerably. We note that the proposed RN requirement of 0.55 HPRD is higher than every State, and only lower than the District of Columbia (DC) based on data from September 2022. Our proposed NA requirement of 2.45 HPRD is higher than all States and DC, based on data reported in September 2022.[36] [39] To reiterate, LTC facilities would be required to meet both the proposed 0.55 HPRD for RNs and the 2.45 HPRD for NAs.
- The relationship between staffing and quality of care and safety, varies by staff type and level as follows:

++ RN hours per resident day of 0.45 or more have a strong association with safety and quality care.

++ NA hours per resident day of 2.45 or more also have a strong association with safety and quality care.

++ LPN/LVN hours per resident day, at any level, do not have any association with safety and quality of care.[40] [41] [42]

- Increasing nursing staffing level is associated with costs, namely financial costs to LTC facilities, as well as benefits, including enhanced safety and quality to varying degrees.

In brief, the 2022 Nursing Home Staffing Study was conducted as a general framework to survey different sources of information and to conduct different types of analyses to help inform the minimum staffing decision process, while considering the potential

[35] Sen Tester, Nursing Home Staffing Mandate, 2023; *https://www.tester.senate.gov/wp-content/uploads/1-20-23-Nursing-Home-Staffing-Mandate-Letter-FINAL.pdf*; Sen Casey, Wyden, et al, Nursing Home Staffing Mandate, 2023; *https://www.aging.senate.gov/imo/media/doc/letter_to_cms_re_regulations_to_establish_minimum_staffing_levels_in_nursing_homes.pdf;* Doggett, Schakowsky Lead Effort Pressing for Strong Nursing Home Staffing Standards | Congressman Lloyd Doggett (house.gov), *https://doggett.house.gov/media/press-releases/doggett-schakowsky-lead-effort-pressing-strong-nursing-home-staffing-standards.*

[36] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[37] Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes (2001) *https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf.*

[38] Five care processes were the following: (1) dressing/grooming; (2) exercise; (3) feeding assistance; (4) changing and repositioning; and (5) providing toileting assistance.

[36] Payment and Access Commission (MACPAC). (2022a). Medicaid and CHIP Payment and Access Commission (MACPAC). (2022a). Compendium: State policies related to nursing facility staffing. *https://www.macpac.gov/publication/statepolicies-related-tonursing-facility-staffing/.*

[39] Consumer Voice (The National Consumer Voice for Quality Long-Term Care) (2021). State nursing home staffing standards: Summary report *https://theconsumervoice.org/issues/otherissues-andresources/staffing.*

[40] Akinci, Fevzi, and Diane Krolikowski. ''Nurse staffing levels and quality of care in Northeastern Pennsylvania nursing homes.'' Applied nursing research: ANR vol. 18,3 (2005): 130–7. doi:10.1016/j.apnr.2004.08.004.

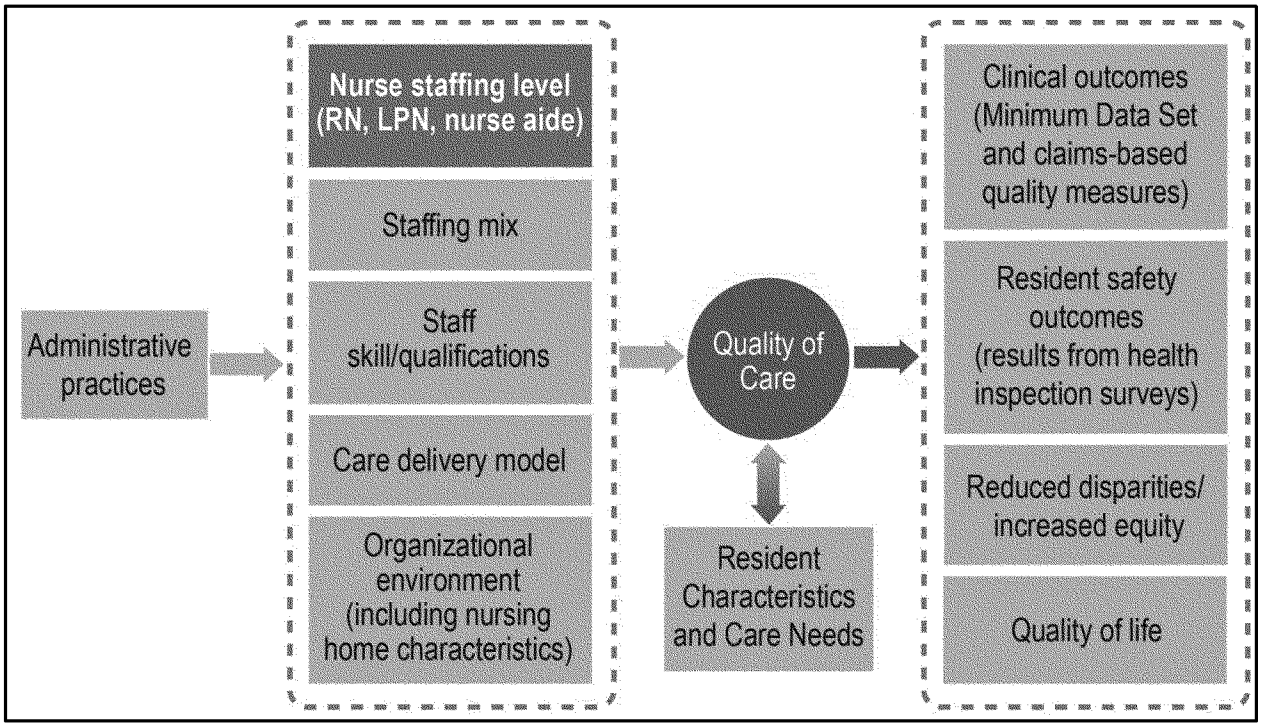
[41] Yang, Bo Kyum et al. ''Nurse Staffing and Skill Mix Patterns in Relation to Resident Care Outcomes in US Nursing Homes.'' *Journal of the American Medical Directors Association* vol. 22,5 (2021): 1081–1087.e1. doi:10.1016/j.jamda.2020.09.009.

[42] Spilsbury, Karen et al. ''The relationship between Nurse staffing and quality of care in nursing homes: a systematic review.'' *International journal of* nursing *studies* vol. 48,6 (2011): 732–50. doi:10.1016/j.ijnurstu.2011.02.014.

cost and benefit. The study [43] was unable to examine the relationship between staffing levels by shift and quality/patient safety because the PBJ System does not include information on staffing by shift. In addition, there was limited information on non-nurse staffing, so the study team was unable to examine minimum staffing standards for non-nurse staff.

Unlike the 2001 CMS Staffing Study, the 2022 Nursing Home Staffing Study was guided by a conceptual model (see Figure 1), that hypothesizes that administrative practices (for example, nurse staffing levels, staffing mix, care delivery model, and organizational environment) influence the quality and safety of care provided in a nursing home, which, in turn, influences nursing home residents' outcomes (that is, clinical, safety, and disparity). Clinical outcomes were defined using Care Compare quality measures derived from the MDS and Medicare claims data. Patient safety was defined using measures from health inspection surveys.

FIGURE B-1: Conceptual Model for Nursing Home Staffing Study.



Adapted from Clarke & Donaldson (2008). Clarke SP, Donaldson NE. Nurse Staffing and Patient Care Quality and Safety. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 25. *https://www.ncbi.nlm.nih.gov/books/NBK2676/.*

(1) Systematic Literature Review

The overall goal of the systematic literature review was to summarize timely and current evidence of the relationship between minimum staffing standards in nursing homes and the safety and quality of care, as well as clarify the relative strengths and weaknesses of the available literature. In addition, the systematic literature review of existing peer-reviewed and ''gray literature'' (that is, published outside the traditional research publications such as opinion pieces, advocacy materials, and non-statistically rigorous research published by government agencies) which includes printed articles, for the initial period 2019–2022, and prior to 2019 if needed, focused on addressing the following questions:

- What is the relationship between nurse staffing levels and safety and quality of care? What minimum staffing levels associated with safety and quality of care have been identified in previous studies, and what is the empirical basis for them?
- What are the current State and Federal standards for staffing level/types and outcomes in nursing homes for weekdays, weekends, and evenings?
- What is the role of different nurse types (that is, RNs/LPN/LVNs/NAs) in ensuring safety and quality of nursing home care?
- What are the costs associated with nurse staffing in nursing homes? What are the costs associated with implementing minimum nurse staffing standards and increasing nurse staffing levels/types?

Most importantly, an increase in nurse staffing was associated with improved quality of care. In a 2021 study, where interview data were examined, and multivariate analyses of resident outcomes were conducted, authors concluded that higher total nurse staffing had a significant correlation with a decreased number of pressure ulcers, an increase in influenza vaccination, an increase in pneumonia vaccination, and decreased number of

[43] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

outpatient emergency department visits.[44]

However, the OBRA of 1987,[45] which amended sections 1819 and 1919 of the Act to mandate staffing standards in nursing homes, did not mandate specific numerical minimum nurse staffing standards. As such several States mandated variable staffing standards to help meet the standards in sections 1819 and 1919 of the Act.

As stated in the 2022 Nursing Home Staffing Study report,[46] which will be published concurrently with this proposed rule, studies found that States that established higher nurse staffing standards resulted in increased staffing within nursing homes, but the magnitude of this increase varied by the staff type. For example, authors found that when the States of California and Ohio required increased licensed nurse or total nurse staffing standards, this resulted in some actual increase in staffing levels. California required facilities to increase the hours for direct resident care per day from 3.0 to 3.2 and prohibited the previous practice of allowing RN or LPN hours to be counted twice, also known as ''doubling''. The rationale for doubling was to increase the number of licensed staff. Ohio law required facilities to increase total nurse staffing (RN, LPN/LVN, and NA) direct care hours from 1.6 to 2.75. Results showed that for both California and Ohio, nursing homes that ranked in the bottom quartile at baseline on total nurse staffing significantly increased their HPRDs for all three types of nursing staff (RN, LPN/LVN, and NA). However, there was a reduction in professional skill mix, meaning there were fewer RNs relative to other direct care staff, 71 percent of the increase in nursing staff represented an increase in NA hours.[47]

Another study, when controlling for changes in State minimum direct care staffing standards during the study period, in Arkansas, Delaware, Florida, and Ohio, found that nursing homes serving a higher share of Medicaid patients reported large increases in staffing, specifically RNs, in response to a one HPRD increase in total nurse staffing from a baseline of 2.0 HPRD requirement for total nurse staffing.[48] In sum, studies found that nursing homes in States with higher minimum staffing standards employed more staff.

Most LTC facilities typically have nurse teams providing care to residents with very few RNs (8 percent) making up the team, compared to other nurse team members, (that is, administrative RNs, LPN/LVNs and unlicensed assisting staff)[49] [50] which suggests that LPN/LVNs provide most of the clinical care with minimal supervision from RNs.[51] Other study findings suggest that some Directors of nursing (DONs) view the roles of RNs and LPN/LVNs interchangeably despite the difference in educational preparation and scope of practice. Yet, study findings suggest that having more RNs in LTC facilities to provide clinical skills and supervision of LPNs positively influences LPNs contributions to improved quality care.[52] In summary, the presence of more RNs on a team influences the quality of care provided.

Based on gray literature, a coalition of resident nursing home advocates and the National Academies of Sciences, Engineering, and Medicine recommended RN coverage, with at least one RN, for 24 hours a day, 7 days a week, with additional RN coverage if needed, as part of the minimum staffing standards.[53] [54]

Several costs for increasing nurse staffing were cited in the literature, we note that these costs differ from our estimated costs as set out in this proposed rule. For example, in one study, by trade groups representing the industry, 4.1 HPRD for total nurse staffing (that is, RNs, LPN/LVNs and NAs) was found to cost the long-term care industry more than $10 billion annually.[55] Another study estimated that the additional staffing costs to meet the 4.1 HPRD for total nurse staffing as $7.25 billion.[56] In summary, several studies found that higher levels of nurse staffing, including RNs, were associated with improved resident care outcomes and increased costs.

(2) Qualitative Analysis

Thirty-one nursing homes were selected for scheduled site visits in 14 States, specifically California, Colorado, Florida, Illinois, Massachusetts, Maryland, Missouri, North Carolina, New York, Ohio, Pennsylvania, Virginia, Washington, and Wyoming. These site visits started in September 2022, and ended in December 2022. nursing homes were selected to ensure a national representation by size, ownership type, geographic location, Medicaid population, and overall rating under the *Five-Star Quality* Rating System. Nursing homes voluntarily participated in these site visits and no incentives were offered. Site visit protocols and interview guides were reviewed and approved by Abt Associates Inc. Institutional Review Board.[57] Site visits were conducted under the Nursing Home Reform Law in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–203), which is exempt from the Paperwork Reduction Act (PRA).

During site visits, interviews (n=361) were conducted with 76 nursing home leadership, 195 direct care staff

[44] Wagner, L.M., Katz, P., Karuza, J., Kwong, C., Sharp, L., & Spetz, J. (2021). Medical staffing organization and quality of care outcomes in post-acute care settings. Gerontologist, 61(4),605–614.

[45] *chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/ https://static1.squarespace.com/static/602ac1a3ede5cc16ae72d619/t/6043c094b391303a2d1c1418/1615052948879/OBRA87summary.pdf.*

[46] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[47] Chen, Min M, and David C Grabowski. ''Intended and unintended consequences of minimum staffing standards for nursing homes.'' *Health economics* vol. 24,7 (2015): 822–39. doi:10.1002/hec.3063.

[48] Bowblis, John R. ''Staffing ratios and quality: an analysis of minimum direct care staffing requirements for nursing homes.'' *Health services research* vol. 46,5 (2011): 1495–516. doi:10.1111/j.1475–6773.2011.01274.x.

[49] American Health Care Association (2012) LTC stats: Nursing facility operational characteristics report. Retrieved from *http://www.ahcancal.org/research_data/oscar_data/Nursing%20Faciliry%20Operational%Characteristics/LTC+STATS_PVNFOPERATIONS_2012Q4_FINAL.pdf.*

[50] Siegel, Elena O et al. ''Leadership in Nursing Homes: Directors of Nursing Aligning Practice With Regulations.'' Journal of gerontological nursing vol. 44,6 (2018): 10–14. doi:10.3928/00989134–20180322–03.

[51] Corazzini, Kirsten N et al. ''Licensed practical nurse scope of practice and quality of nursing home care.'' Nursing research vol. 62,5 (2013): 315–24. doi:10.1097/NNR.0b013e31829eba00.

[52] Corazzini, Kirsten N et al. ''Licensed practical nurse scope of practice and quality of nursing home care.'' Nursing research vol. 62,5 (2013): 315–24. doi:10.1097/NNR.0b013e31829eba00.

[53] California Advocates for Nursing Home Reform, Center for Medicare Advocacy, Justice in Aging, Long Term Care Community Coalition, Michigan Elder Justice Initiative, and The National Consumer Voice for Quality Long-Term Care. (2021). Framework. for nursing home reform post COVID–19. *https://theconsumervoice.org/uploads/files/actionsand-newsupdates/Framework_and_overview_FINAL.pdf.*

[54] National Academies of Sciences, Engineering, and Medicine.(2022).The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff. The National Academies Press. *https://doi.org/10.17226/26526.*

[55] CLA (CliftonLarsonAllen, LLC). (2022). Staffing mandate analysis. In-depth analysis on minimum nurse staffing levels and local impact. American Health Care Association and the National Center for Assisted Living (AHCA/NCAL). *https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/CLA-Staffing-Mandate-Analysis.pdf.*

[56] Hawk, T., White, E.M., Bishnoi, C., Schwartz, L.B., Baier, R.R., & Gifford, D. R. (2022). Facility characteristics and costs associated with meeting proposed minimum staffing levels in skilled nursing facilities. Journal of the American Geriatrics Society, 70(4), 1198–1207. *https://doi.org/10.1111/jgs.17678.*

[57] *https://abtimpact.com/mission-impact-2020/ethics-and-governance/.*

(including RNs, LPN/LVNs, and NAs), 65 residents, and 25 family members to better understand the relationship between staffing levels, staffing mix (what types of staff are present), and resident outcomes and experiences (that is, clinical outcomes, safety, health disparities). Staff completed 168 Missed Nursing Care *(MISSCARE)*[58] surveys to determine any omitted or delayed care.

Findings from data analyses of surveys and interviews highlighted that activities of daily living care tasks, including bathing, toileting, and mobility assistance, are the most frequently delayed tasks when shifts/units are short staffed. Family members also reported that quality of life, quality of care, and resident safety are adversely affected when nursing homes are short staffed. Some staff stated that rushing through care due to having high-acuity residents, meaning that their condition is severe and imminently dangerous, or a high number of assigned residents led to medication errors and safety issues. For example, one nurse stated that being assigned 33 patients without any other staff is not safe. Respondents also noted that different staffing requirements for NAs and licensed nurses, among other factors, should be considered when developing minimum staffing standards. Nursing home staff respondents also suggested minimum staff-to-resident ratios. NA respondents proposed a ratio of 5 to 14 residents per NA, whereas RNs and LPN/LVNs suggested ratios from 8 to 25 residents per licensed nurse (RN and LPN/LVNs). Respondents worked across a variety of shifts, units, and resident types (for example, skilled nursing/rehabilitation, long-term care, total care, dementia care, and behavioral issues), so the acuity of residents they typically supported varied as did the ratios they proposed.

(3) Observation Study/Simulation Modeling

Twenty LTC facilities were selected based on a convenience sampling method for the observation study. Time data of 8,249 unique care tasks were collected via direct observations of licensed nursing staff (that is, RN and LPN/LVNs) providing common clinical tasks including medication pass, resident assessment, wound care, and catheter/device care. Previous simulation modeling research focused on NAs providing non-clinical tasks specifically, activities of daily living (ADL) tasks,[59] but not on clinical tasks. Thus, this simulation study was aimed at addressing this gap in knowledge and focused exclusively on specific clinical tasks provided by licensed nurses.

These data were used to develop a simulation model to examine the impact of different levels of licensed nurses and resident acuity, on the quality and timeliness of providing certain care tasks defined as delayed and omitted care respectively. This simulation model is important to add to existing literature on delayed care and help the staffing study reflect not just what staffing levels exist currently as a descriptive model, but also what staffing levels are needed for safe, quality care for residents at varying acuity levels for the studied clinical tasks.

As stated in the 2022 Nursing Home Staffing Study report,[60] which will be published concurrently with this proposed rule, simulation findings suggest that a staffing level of four licensed nurses (that is, a combination of RNs and LPN/LVNs) in this setting, would reduce the amount of delayed or omitted care for the clinical tasks studied to a rate below 5 percent in a 70-resident nursing home. Five licensed nurses would virtually eliminate delayed or omitted care in this setting. The 4 to 5 licensed nurses correspond to approximately 1.4 to 1.7 HPRD at such a nursing home. However, the study has several limitations. One is that these study observations did not differentiate between RN and LPN/LVN tasks, so we are unable to separate estimates of potential delayed or omitted care for an RN versus an LPN. Most importantly, simulation studies did not incorporate any patient-level data or facility-level data from site observations. Instead, simulations estimated patient acuity using MDS data. Therefore, patient acuity in simulations were based on population-level estimates, rather than estimates at the nursing-home level or the individual patient level.

Because the simulation did not use actual patient- or facility-level data, facilities specializing in treatment of high or low acuity residents were not properly represented in the staffing simulation models. For example, different staffing needs may arise in facilities specializing in care for persons experiencing disabilities resulting in paraplegia/quadriplegia, or in facilities specializing in persons experiencing advanced cognitive impairment. Analysis of specialized care facilities was outside of the scope of this simulation research. Furthermore, other existing simulation research focused on NAs only, so NAs were considered as part of the evidence base for this work but were not included in the analysis.

(4) Quantitative Analysis

Secondary Analysis: The quantitative analysis used secondary data of nursing homes (n = 14,529) from the CMS' PBJ System, the MDS 3.0, Medicare cost reports, and health inspection surveys to establish minimum staffing standards for different types of nurse staff (that is, total nurse staffing and individual RNs, LVN/LPNs, and NAs) and for non-nurse staff (that is, social workers, feeding assistant, other activities staff, and physical therapy assistant among others) that is associated with an acceptable quality of care and safety in nursing homes. Quality was defined based on a total composite quality measure made up of *Short-Stay Measures* (that is, community discharge, hospital readmissions, emergency department visits, Functional improvement) and *Long-Stay Measures* (that is, activities of daily living decline, antipsychotic medication use, mobility decline, high-risk pressure ulcer, hospitalizations, and emergency department visits).[61]

Safety was measured based on the relative on-site health inspection performance of nursing homes within a State using surveys for the following deficiencies: Immediate jeopardy to resident health or safety; Actual harm that is not immediate jeopardy; No actual harm with potential for more than minimal harm that is not immediate jeopardy; and, No actual harm with potential for minimal harm.

Similar to other CMS nursing home improvement quality initiatives such as Value Based Payment for nursing homes, acceptable quality and safety was defined using the 25th and 50th percentile cut-offs on the current distribution of the total quality measure (QM) score and within-State performance on health inspection survey data, based on the predicted probability of nursing homes exceeding the threshold across the full distribution of nurse staffing levels. Moreover, some

[58] Kalish, B.J., & Williams, R.A. (2009). Development and psychometric testing of a tool to measure missed nursing care. The Journal of Nursing Administration, 39(5), 211–219. *https://doi.org/10.1097/nna.0b013e3181a23cf5.*

[59] Schnelle, J.F., Schroyer, L.D., Saraf, A.A., & Simmons, S.F. (2016). Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *Journal of the American Medical Directors Association, 17*(11), 970–977. *https://doi.org/10.1016/j.jamda.2016.08.006.*

[60] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[61] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

nursing homes are staffed at levels that place their residents at substantially higher risk of poor quality (for example, being in the lowest quartile of QM score, defined as the 25th percentile cut off) and low safety (for example, lowest quartile of performance on health inspection survey, defined as the 25th percentile cut off). The PBJ System data for the fourth quarter of 2019 through the first quarter of 2022, for 14,688 Medicare and/or Medicaid certified nursing homes in the United States were included in the analyses.

Descriptive analyses examined HPRD for nurse and non-nurse staff in nursing homes (n=14,529) across all States. Regression modeling analyses controlled for case-mix adjusted data for nurse staffing (that is, RN, LPN/LVN, and NA), LTC facility ownership (for example, non-profit, Government), percent of Medicaid residents, hospital-based facility, Continuing Care Retirement Community (CCRC) facility, rural location, number of certified beds (per 1-bed increase), and Special Focus Facility status. Using a correlational descriptive analysis, findings indicate that there is a consistent positive relationship between higher RN staffing and better performance, regardless of the measure (that is, total quality measure score or within-State health inspection score), the performance standard (that is, acceptable quality and safety at the 25th, or 50th percentile), or the case-mix adjusted RN staffing decile measured in HPRD.

Among all nurse staffing types, RNs exhibit the strongest association with acceptable quality ($p<.0001$, significant at $\alpha = 0.05$) and safety (pHowever, similar to previous analyses,[62] [63] [64] this study found no relationship between LPN/LVNs HPRD levels and quality care and safety. This finding may be influenced by the LPN/LVN's role [65] and the fact that nursing homes with higher LPN/LVN staffing levels tend to have lower RN staffing levels.[66] The volume and number of HPRD reported in PBJ System for non-nurse staff were very low, ranging from 0.00–0.11; as such were insufficient to examine further for establishing minimum non-nurse staffing standards.

We considered findings from the 2022 Nursing Home Staffing Study, specifically that there was no statistically significant difference in safety and quality care below 2.45 HPRDs for NAs. In other words, staffing below 2.45 HPRD for NAs did not improve safety and quality care for LTC facility residents. Also, our proposed NA requirement of 2.45 HPRD which was developed using case-mix adjusted data sources, is higher than the minimum requirements in all States and DC, based on data reported in September 2022.

We also considered findings from the 2022 Nursing Home Staffing Study that there was no correlation between safety and quality care, and LVN/LPNs. We examined findings from the 2022 Nursing Home Staffing Study, that there was a statistically significant difference in safety and quality care at 0.45 HPRD for RNs and higher. We also factored the minimum RN requirements in all States and the District of Columbia, which with the exception of two States, all had less than the 0.45 HPRD for RNs, which was the lowest level presented in the 2022 Nursing Home Staffing Study. However, current State minimum RN staffing levels are associated with increased risk for unsafe and poor quality care. Therefore, we are proposing the level of 0.55 HPRD for RNs, which was developed based on case-mix adjusted data sources and the 2022 Nursing Home Staffing Study findings. In addition, 0.55 HPRD for RNs will result in a large majority (78 percent) of LTC facilities increasing staffing to provide safe and quality care. CMS is also seeking comments on whether in addition to the 0.55 RN and 2.45 NA HPRD standards, a minimum total nurse staffing standard, such as 3.48 among other alternatives, discussed later in the rule, should also be required.

Furthermore, we considered striking a balance between cost and benefit for LTC facilities, nursing staff, and residents, and the minimum number of HPRDs by staff type that will improve safety and quality care. Therefore, we proposed 0.55 and 2.45 HPRD for RNs and NAs, respectively, which were developed using case-mix adjusted data sources, because we believe that proposing lower staffing levels than current State requirements would be insufficient to meet the statutory goals of improving health and safety.

Impact Analysis: The impact of State minimum staffing policies on nurse staffing, and safety and quality care in nursing homes during the recent COVID–19 PHE, can inform policy makers on potential outcomes to Federal minimum staffing standards. The study also provided analyses of the recently revised Massachusetts minimum staffing standards, in the wake of the COVID–19 PHE, making the findings the most timely and relevant of various State-level analyses. The researchers determined that the analysis of the Massachusetts staffing standard would be particularly informative given that the State increased its HPRD to a relatively high level and incorporated a Medicaid payment reduction of 2 percent for noncompliant facilities. As such a quasi-experimental study was conducted to determine the impact of the Massachusetts minimum staffing standards on quality of care and safety in nursing homes.

The Massachusetts nursing home minimum staffing standards requires 3.58 HPRD for total nurse staffing (that is, RN, LPN, and NA), of which 0.508 HPRD was for an RN, and provided for a financial penalty for noncompliance with the total nurse staffing standard. The study period was defined as 2015 Q3 through 2022 Q2. The Massachusetts nursing home minimum staffing policy was effective January 1, 2021. Impact analysis of existing nursing homes (n=40) data from the PBJ System data (2015Q3–2022Q2) and Care Compare (quality measure and health inspection survey data) were used. The comparison group selected from the sample of national nursing homes (n=1,617) was constructed using a synthetic control approach. Synthetic control is a statistical method for creating a comparison group of nursing homes from a region that did not experience the same health policy intervention, but closely resembles the nursing home staffing level and trend in Massachusetts using weighted estimates. Difference-in-differences regression analyses were conducted by stratified nursing home Medicaid share and staffing level. Difference-in-differences regression is a statistical method for estimating the causal effect of the Massachusetts minimum staffing standards, when compared to a region that did not experience the same policy intervention.

[62] Akinci, Fevzi, and Diane Krolikowski. ''Nurse staffing levels and quality of care in Northeastern Pennsylvania nursing homes.'' Applied nursing research: ANR vol. 18,3 (2005): 130–7. doi:10.1016/j.apnr.2004.08.004.

[63] Yang, Bo Kyum et al. ''Nurse Staffing and Skill Mix Patterns in Relation to Resident Care Outcomes in US Nursing Homes.'' *Journal of the American Medical Directors Association* vol. 22,5 (2021): 1081–1087.e1. doi:10.1016/j.jamda.2020.09.009.

[64] Spilsbury, Karen et al. ''The relationship between Nurse staffing and quality of care in nursing homes: a systematic review.'' *International journal of* nursing *studies* vol. 48,6 (2011): 732–50. doi:10.1016/j.ijnurstu.2011.02.014.

[65] Firnhaber, G.C., Roberson, D.W., & Kolasa, K.M. (2020). Nursing staff participation in end-of-life nutrition and hydration decision-making in a nursing home: A qualitative study. Journal of Advanced Nursing, 76(11), 305–3068.*https://doi.org/10.1111/jan.14491.*

[66] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

These regression models did not find a discernible impact on quality of care nor safety within the time period studied. They did, however, find an increase in total nurse staffing levels among low-staffed nursing homes with a high share of residents with Medicaid in Massachusetts. The observed staffing increase was significant for NAs (average treatment effect on the treated (ATT)=.179, p=0.03). The analysis thus demonstrates that nursing homes were able to expand staffing in response to the new requirement, notwithstanding workforce challenges since the pandemic.

One limitation of the analysis was the small number of nursing homes included because the analysis focused on a subset of nursing homes with the strongest incentive to respond to the new policy, that is, those with high Medicaid resident shares (≥ 75th percentile) and initial staffing levels below the new Massachusetts minimum staffing requirement (HPRD ≤ 3.58 for total nurse staffing), resulting in 1,617 out of 15,333 nursing homes nationwide for the control group, and 40 out of 373 nursing homes in Massachusetts. Also, about one third of the nursing homes did not complete health inspection surveys due to the COVID–19 PHE, so there was a substantial amount of missing data for examining the safety outcome. Furthermore, the analysis of quality of care and safety outcomes was limited by the short post-implementation study period of Massachusetts's minimum staffing standards, which does not allow for sufficient time for a complete evaluation of the policy. Additionally, the impact analysis was focused on data from roughly the first year of implementation, which usually involves resource planning and operational changes to meet the new policy standards, and thus may not be representative.

These study results show that there was an increase in NA staffing, which supports the proposed policy to require facilities to meet the minimum staffing standards or otherwise be subject to, civil money penalties and denial of payment for all Medicare and/or Medicaid individuals among other penalties in accordance with 42 CFR 488.406.

(5) Cost and Savings Analysis

The cost analyses were conducted to determine any associated incremental costs that nursing homes would likely experience to meet minimum staffing standards, as well as any Medicare savings. Cost analyses used the 2021 Q2 PBJ System (staffing data), facility-specific information on hourly costs for RNs, LPN/LVNs, and NAs from *Worksheet S–3, FY 2021 Part V* of the Medicare Cost Report for 14,688 SNFs, and information on resident census that is available from files produced for comparison to evaluate any associated incremental costs. We note that the cost analyses were independent of a facility's case-mix.

Study findings indicate that the staffing costs for increasing RN and NA staffing levels in nursing homes to meet the minimum staffing standards ranges from $2.2 to $6.0 billion per year. The minimum estimated cost savings to Medicare, based on savings from the RN staffing requirement, are from the decreased use of acute care services (fewer hospitalizations and emergency department visits) and increased community discharges (defined as a reduction in Medicare-covered SNF days); cost savings ranges from $187 to $465 million. The decision to focus on estimated savings for RNs only, was because RN staffing levels were found to have a much stronger and a more consistent positive correlation with hospitalizations and emergency department visits than NAs or LPNs.

These quantitative analyses of savings to Medicare were limited to quality metrics for which there are extant secondary data. However, there are likely additional benefits to quality of care and life that cannot be fully identified through the analysis in the 2022 Nursing Home Staffing Study. Moreover, these analyses do not consider facilities' existing resources, ability to pay for possible staffing levels, or access to trained healthcare professionals.

Overall, the study [67] was unable to examine the relationship between staffing levels by shift and quality/patient safety because the PBJ System does not include information on staffing by shift. In addition, there was limited information on non-nurse staffing, so the study team was unable to examine minimum staffing standards for non-nurse staff.

c. Listening Sessions

In addition to commissioning the 2022 Nursing Home Staffing Study and issuing the FY 2023 SNF PPS RFI, we also held two listening sessions on June 27, 2022, and August 29, 2022, to provide information on the study and solicit additional input on the study design and approach for establishing minimum staffing standards. The first listening session was attended by 18 interested parties representing various groups within the LTC community. During this session, this small group discussed several ''big picture'' questions about minimum staffing standards and provided input on the overall study approach. The second listening session was attended by 668 participants who offered feedback on specific questions that were included on the registration form, such as how to ensure that health equity/health care disparities are addressed when establishing minimum nurse staffing standards and how minimum staffing standards should consider differences in costs for job categories and variations across States.

During the August 2022 listening session,[68] participants shared their opinions that the current state of staffing standards was not adequate, and there was consensus that minimum staffing standards should be the same across the country. Participants recommended that CMS consider resident characteristics and care needs when developing staffing standards. Participants indicated that the interdisciplinary team and the care provided by non-nursing staff such as physical, occupational, speech therapists, respiratory therapists (especially with pediatric specialty/ventilator units), podiatrists, and psychiatrists also need to be considered. Others also suggested that the inclusion of non-nurse staff to meet staffing standards may positively contribute to aspects of quality of life for residents.

Similar to the suggestions received in the FY 2023 SNF PPS RFI, some participants suggested that CMS create a staff-to-resident ratio minimum standard, which can further support a HPRD staffing standard. Participants also suggested that facilities should report and display staff-to-resident ratios on a daily basis for all shifts. Participants in favor of a staff-to-resident ratio requirement noted that increased transparency will help residents and family members to easily determine if the facility is in compliance with minimum staffing standards.

Lastly, some participants indicated that minimum staffing standards should consider the need for consistent NA qualifications across all 50 States and to allow for more online training to eliminate the backlog of availability for NAs testing and increase the availability of classes near candidates to support staff shortages.

[67] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[68] *https://www.cms.gov/nursing-homes.*

4. Ongoing CMS Initiatives and Programs Impacting LTC Facilities

In establishing the proposed minimum staffing standards, we also considered ongoing CMS policies, programs, and operations, including Medicaid institutional payment and transparency, the SNF prospective payment system, the SNF Value-based Purchasing Program (SNF VBP), oversight and enforcement, and CMS policies intended to enhance access to Medicaid home and community-based services and promote community-based placements.

a. Medicaid Institutional Payments and Payment Transparency

In this proposed rule we are also proposing a Medicaid Institutional Payment Transparency provision that is intended to promote public payment transparency. Greater transparency will help us assess the extent to which LTC facilities with a large Medicaid population have challenges achieving compliance with minimum staffing standards. State Medicaid Agencies would be required to publicly report the percentage of payments expended for direct care workers and support staff services in Medicaid-participating nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) (see section III. of this proposed rule). We expect that as a result of this transparency requirement, some facilities would likely increase staffing independent of our proposed minimum staffing standards.

b. Medicare Skilled Nursing Facility Prospective Payment System

The Medicare Skilled Nursing Facility Prospective Payment System is a comprehensive per diem rate under Medicare for all costs for providing covered Part A SNF services (that is, routine, ancillary, and capital-related costs). There are over 15,000 Medicare-certified SNFs. The FY 2023 SNF PPS proposed rule published on April 4, 2023 updated Medicare payment policies and rates for SNFs for FY 2024. The FY2023 SNF PPS proposed rule estimated that the aggregate impact of the payment policies in the rule would result in a net increase of 3.7 percent, or approximately $1.2 billion, in Medicare Part A payments to SNFs in FY 2024. We note that Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. These updates take into account a number of factors, including but not limited to, wages, salaries, and other labor-related costs. Specifics regarding the process to update SNF PPS payment rates are discussed in the rule.[69]

c. Skilled Nursing Facility (SNF) Value-Based Payment (VBP) Program Staffing Measure

In the FY 2023 SNF PPS final rule, we adopted a new Total Nurse Staffing quality measure under the SNF VBP Program, which is used to provide an incentive to LTC facilities for improving quality of care provided to residents.[70] Performance on the Total Nurse Staffing measure begins in FY 2024, and payment adjustments based on performance on this measure (as well as others) occurs in FY 2026. This is a structural measure that uses auditable electronic data reported to CMS' PBJ system to calculate HPRD for total nurse staffing. Our proposal is not to be duplicative of this existing measure; rather, we expect our proposed minimum staffing standards to be complementary by establishing a consistent and broadly applicable national floor at which residents are at a significantly lower risk of receiving unsafe and low-quality care. At the same time, the Total Nurse Staffing quality measure will drive continued improvement in staffing across LTC facilities.

d. Nursing Home Survey and Enforcement

The LTC minimum staffing standards proposed in this regulation are part of the Federal participation requirements for LTC facilities and these Federal participation requirements are the basis for survey activities and for the minimum health and safety requirements that must be met and maintained to receive payment and remain as a Medicare or Medicaid provider. As such compliance with these requirements will be assessed through CMS' existing survey, certification, and enforcement process.[71] Enforcement actions taken against LTC facilities that are not in compliance with these Federal participation requirements are called remedies. The agency that conducts on-site surveys cites deficiencies that indicate the specific Federal participation requirements that the facility did not meet. Sections 1819(h) and 1919(h) of the Act, as well as 42 CFR 488.404, 488.406, and 488.408, provide that CMS or the State may impose one or more remedies in addition to, or instead of, termination of the provider agreement when the CMS or the State finds that a facility is out of compliance with the Federal participation requirements. Specifically, enforcement remedies that may be imposed include the following:

- Termination of the provider agreement;
- Temporary management;
- Denial of payment for all Medicare and/or Medicaid individuals by CMS;
- Denial of payment for all new Medicare and/or Medicaid admissions;
- Civil money penalties;
- State monitoring;
- Transfer of residents;
- Transfer of residents with closure of facility;
- Directed plan of correction;
- Directed in-service training; and
- Alternative or additional State remedies approved by CMS.

In general, to select the appropriate enforcement remedy(ies), the scope and severity levels of the deficiencies is assessed. The severity level reflects the impact of the deficiency on resident health and safety and the scope level reflects how many residents were affected by the deficiency. The survey agency determines the scope and severity levels for each deficiency cited at a survey.

As part of these survey and enforcement activities, we currently publish data for all LTC facilities on the Care Compare website, including number of certified beds, an overall Five Star rating, and three individual star ratings in the categories of inspections, staffing, and quality measurement.[72] In addition, individual performance measures are included on Care Compare. With respect to staffing, this includes the following staffing data: total number of nurse staff HPRD, RN HPRD, LPN/LVN HPRD, and NA HPRD, as well as some additional staffing measures, including weekend hours. These published data are collected through a variety of mechanisms, including during CMS surveys (inspection data), through the reporting

[69] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2024. *https://www.federalregister.gov/documents/2023/04/10/2023-07137/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.*

[70] *https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2023-skilled-nursing-facility-prospective-payment-system-final-rule-cms-1765-f.*

[71] *https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationenforcement/nursing-home-enforcement.*

[72] Centers for Medicare & Medicaid Services *Medicare.gov.* Find and Compare Nursing Homes Providers near you *https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true.*

of PBJ System and are also self-reported by LTC facilities to us.

In general, facilities report employing three types of nursing staff: RNs, LPNs/LVNs, and NAs. We have been moving towards more data-driven enforcement, including use of the self-reported PBJ System data to guide monitoring, surveys and enforcement of existing staffing requirements. We continue to recognize the value of assessing the sufficiency of a facility's staffing based on observations of resident care conducted during the onsite survey. For example, while compliance with numeric minimum staffing standards could be assessed using PBJ System data, it is possible that due to a facility's layout, management, and staff assignments, a facility could meet the numeric staffing standards but not provide the sufficient level of staffing needed to protect residents' health and safety. Resident health status and acuity (for example, proportion of residents with cognitive decline or use of ventilators) are also factors in determining adequate staffing. Therefore, when assessing the sufficiency of a facility's staffing it is important to note that any numeric minimum staffing requirement is not a target and facilities must assess the needs of their resident population and make comprehensive staffing decisions based on those needs. The additional requirements proposed in this rule to bolster facility assessments are intended to address this need and guard against any attempts by LTC facilities to treat the minimum staffing standards included here as a ceiling, rather than a floor.

In summary, the benefits and success of minimum staffing standards are heavily dependent on the survey process. Therefore, in establishing numerical minimum staffing standards our goal is to ensure that they are both implementable and enforceable, as determined through both the PBJ System as well as on-site surveys.

e. Medicaid Home and Community-Based Services

We remain committed to a holistic approach to meeting the long-term care needs of Americans and their families. This requires a focus on access to high-quality care in the community while also ensuring the health and safety of those who receive care in LTC facilities. In the proposed April 2023 Ensuring Access to Medicaid Services (Access NPRM) and Medicaid and CHIP Managed Care Access, Finance, and Quality (Managed Care NPRM), we proposed several policies intended to work alongside those included in this proposed rule. These proposals require that at least 80 percent of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for the direct care workforce (as opposed to administrative overhead or profit); establish standardized reporting requirements related to health and safety, beneficiary service plans and assessments, access, and quality of care; and promote transparency through public reporting on quality, performance, compliance as well as Medicaid managed care plans' payment rates for direct care workers. Additionally, we remain committed to facilitating transfers from LTC facilities to the community through the continued implementation of the Money Follows the Person program.[73]

Notably, we believe that the proposed minimum staffing standards will improve quality of care which includes facilitating the transition of care to community based care services; similar to findings that are reported in the 2022 Nursing Home Staffing Study as well as potential Medicare savings.

B. Provisions of the Proposed Regulations

As discussed above, meeting minimum staffing standards may be influenced by and/or affect existing CMS initiatives and programs, and programs within LTC facilities. Given these factors and the broad spectrum of suggestions and inputs discussed, we acknowledge that there are many considerations and potential policy options for establishing minimum staffing standards. Therefore, we propose a comprehensive staffing approach that consists of the three following elements: (1) establishing new minimum nurse staffing standards based on case-mix adjusted staffing; (2) revising the on-site RN requirement; and (3) revising the existing facility assessment requirement. We believe, when taken together, these three elements will establish a consistent and broadly applicable national minimum staffing standards as a floor, while also ensuring that LTC facilities staff beyond the minimum staffing standards as needed, based on their resident population.

While we expect LTC facilities to meet the comprehensive staffing standards, we acknowledge that there may be circumstances related to the nursing workforce that require efforts to both ensure access to care and maintain quality care and safety. Therefore, we are proposing options for exemptions and a staggered implementation of the proposal's components for meeting the minimum staffing standards. This comprehensive approach aims to strike the appropriate balance between ensuring resident health and safety, while guarding against unintended consequences, and preserving access to care.

Our goal is to protect resident health and safety and ensure that facilities are considering the unique characteristics of their resident population in developing staffing plans, while balancing operational requirements and supporting access to care. Moreover, the comprehensive staffing standards will provide staff with the support they need to safely care for residents.

We believe that the elements of the proposed comprehensive staffing standards discussed in this rule support these goals and align with the key function of the LTC facility participation requirements, which is to establish minimum standards to ensure safety and quality care for all residents.

We also acknowledge the impact that proposed minimum staffing standards will have on the LTC facility industry and recognize the potential for unintended consequences, such as facilities' misinterpretation of the minimum staffing standards. Such misinterpretation could result in inappropriate behaviors, such as choosing to staff only at the minimum RN and NA HPRD requirements, without adequate consideration of facility characteristics and resident acuity and needs; healthcare workforce substitution (hiring for one position by eliminating another); task diversion (assigning non-standard tasks to a position); or gamesmanship around composition of the patient population (avoiding residents with more complex medical needs). Such actions would not result in the improved safety, quality, and person-centered care that we seek in facilities. As such, we are soliciting public comments on the policy proposals outlined below, in particular the feasibility of the proposals, any unintended consequences, and alternatives that we should consider. We will consider all feedback to inform the final policy.

1. Nursing Services (§ 483.35)

a. Sufficient Staff (§ 483.35(a)(1))

In general, LTC facilities report employing three types of nursing staff: RNs, LPN/LVNs, and NAs. RNs are assigned both administrative roles and resident assessment and care planning, which typically results in less hands-on

[73] Money Follows the Person | Medicaid, *https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html.*

time with residents and more non-clinical skills (for example, managerial and time management skills). They are able to assess resident health problems and needs, develop and implement care plans, and maintain medical records. LPN/LVNs are entry-level licensed nurses providing basic level care under a RN or physician supervision such as checking blood pressure, changing bandages and dressings, and documenting patient care records. NAs spend the most time providing care to residents by assisting with activities of daily living (for example, feeding, bathing, and dressing). Moreover, roles for NAs may differ from LPN/LVNs depending on the State.

NAs are paid on average $16.90/hour, whereas RNs and LVN/LPNs are paid an average hourly wage of $37.11 and $28.17 in Nursing Care Facilities.[74] While the work of NAs and other direct care workers, like home health aides and personal care assistants, requires considerable technical and interpersonal skills, these workers historically receive low pay, rarely receive benefits, and experience high injury rates.[75] Despite the rising demand for services, direct care workers continue to earn poverty-level low wages. Almost one-half of the direct care workforce (45 percent) live below 200 percent of the Federal poverty level and about one-half (47 percent) rely on public assistance. Recent research by the U.S. Assistant Secretary for Planning and Evaluation finds that wages for direct care workers, including NAs, lag behind workers in other industries with similar entry-level requirements, exacerbating recruitment and retention challenges. According to its findings, average hourly wages also vary considerably State to State—as low as $10.90 for NAs in Louisiana to as high as $18.66 in Alaska.

Current regulations at § 483.35(a)(1)(i) and (ii) require facilities to have sufficient numbers of licensed nurses and other nursing personnel, including but not limited to NAs, available 24 hours a day to provide nursing care to all residents in accordance with the resident care plans.[76] In the 2016 LTC final rule mentioned previously,[77] CMS described the complexity of establishing minimum staffing standards at that time given that the PBJ System reporting program had only been recently implemented. Therefore, we did not have adequate information in terms of facility-level staffing data that would be needed to establish minimum staffing standards. We further stated that once a sufficient amount of data was collected and analyzed, we could re-visit the establishment of minimum staffing standards in LTC facilities. As of calendar year 2022, we have access to about 6 years of self-reported data from the PBJ System which are sufficient to examine the staffing issues in LTC facilities that still persist and were exacerbated by the COVID–19 PHE.

According to CMS survey and enforcement data, over 1,000 facilities were cited for insufficient staffing in 2022 and residents, family, ombudsmen, researchers, and others continue to report to CMS that understaffing negatively affects care. There is also considerable variation in State staffing requirements. As previously stated, a review of State staffing requirements indicates that 38 States and the District of Columbia currently have minimum staffing standards in LTC facilities, but these standards differ across States by staff types, hours and measurement across States, and more so during the COVID–19 PHE.[78] The proposed RN requirement of 0.55 HPRD is higher than every State, and only lower than the District of Columbia. The proposed NA requirement of 2.45 HPRD is higher than all States and the District of Columbia, based on data from September 2022.

For example, only 10 States out of the 38 States have minimum HPRD standards for NAs ranging from 1.04 to 2.44 (see Table 2).

TABLE 2—HPRD REQUIREMENT FOR NAS BY STATE

State	CNAs (HPRD)
1. California	2.4
2. Delaware	1.6
3. Florida ‡	2.0
4. Montana	1.2
5. New Jersey	1.04
6. New York	2.2
7. Oregon	2.16
8. Rhode Island	2.44
9. South Carolina	1.63
10. Vermont	2.0

Notes: CNAs= certified nursing assistants or nursing assistants; HPRD= hours per resident day.

‡ FL revised CNA HPRD from 2.45 to 2.0 on 4/2022.

Source: RTI International, 2021, Review of State Policies Related to Nursing Facility Staffing.

Some States have implemented a total hour per resident day (HPRD) model, with some including licensed nurses in this calculation, whereas others exclude LPN/LVNs but include RNs, DONs, and NAs only. For example, the District of Columbia requires a minimum daily average of 4.1 hours of direct nursing care per resident per day (with an opportunity to adjust the requirements above or below this level, as determined by the Director of the Department of Health), an RN on site 24 hours a day, 7 days a week, plus additional nursing and medical staffing requirements.[79] Some States implemented a ratio of numbers of full-time equivalent NAs per resident. For example, California requires 3.5 HPRD for total nurse staffing with at least 0.24 of those hours provided by RNs, and 2.4 HPRD for NAs, and no HPRD required for LPN/LVNs. Massachusetts requires 3.58 HPRD for total nurse staffing with at least 0.508 of those hours provided by a RN.[80] Arkansas requires at least 3.36 average HPRD for nurse and non-nurse staff each month to include licensed nurses, NAs, medication assistants, physicians, physician assistants, licensed physical or occupational therapists or licensed therapy assistants, registered respiratory therapists, licensed speech language pathologists, infection preventionists, and other healthcare professionals licensed or certified in the State, plus requirements for minimum numbers of licensed nurses per residents per shift. There is also limited evidence on how these different staffing standards were developed and their impact.

[74] *Nursing and Residential Care Facilities—May 2022 OEWS Industry-Specific Occupational Employment and Wage Estimates (bls.gov).*

[75] Wages of Direct Care Workers Lower than Other Entry Level Jobs in most States, Assistant Secretary for Planning and Evaluation, April, 2023 *https://aspe.hhs.gov/reports/dcw-wages.*

[76] 42 CFR 483.35 *https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.*

[77] Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. (81 FR 68688) *https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities.*

[78] State Policies Related to Nursing Facility (NF) Staffing *https://www.macpac.gov/wp-content/uploads/2022/03/State-Policies-Related-to-Nursing-Facility-Staffing.xlsx.*

[79] *https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Nursing_Facility_Regulations_Health_Care_Facilities_Improvement_2012.pdf.*

[80] *https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf.*

The 2022 Nursing Home Staffing Study [81] included an analysis of PBJ System data for the fourth quarter of 2019 through the first quarter of 2022. The 2022 Nursing Home Staffing Study, as discussed previously, provided CMS with findings to inform the proposal for minimum staffing standards, and discussed trade-offs associated with balancing cost and feasibility with implications for acceptable quality care and safety, especially among the lowest performing facilities (that is, at or below the 25th percentile for total safety and quality measure scores) that are at the most risk for providing unsafe care.

After considering all of the available evidence and extensive comments provided, we are proposing revisions to the Nursing Services regulations at § 483.35 to establish national, quantitative minimum staffing standards to ensure all facilities provide at least the same baseline level of high-quality and safe care to residents across all participating LTC facilities. We propose to revise § 483.35(a)(1)(i) and (ii) to further define ''sufficient numbers'' by establishing a numerical minimum level for HPRD for RNs and NAs. We also propose to revise § 483.5 to include the definition of ''hours per resident day'' (HPRD), that is, staffing hours per resident per day is the total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS.[82] Specifically, at § 483.35(a)(1)(i) we propose individual nurse staffing type standards for RNs and NAs. We propose to require facilities to have minimum staffing standards of 0.55 HPRD of RNs and 2.45 HPRD of NAs as well as to maintain sufficient additional nursing personnel, including but not limited to LPN/LVNs, and other clinical and non-clinical staff, to ensure safe and quality care, based on the proposed facility assessment requirements at § 483.71. CMS is also seeking comments on a minimum total nurse staffing standard of 3.48 HPRD discussed later in the rule.

We are not proposing minimum nurse staffing standards that include HPRD for licensed nurses (that is, RNs plus LPN/LVNs) nor for total nurse staffing (that is, RNs, LPN/LVNs, and NAs). This proposed policy is based on the 2022 Nursing Home staffing study findings and other literature evidence demonstrating that RNs and NAs have a larger effect on quality than LPN/LVNs. In addition, literature and statistical evidence suggests that improved clinical outcomes are associated with increasing the HPRD rates of RNs and NAs [83] especially among nursing homes that have a high reliance on Medicaid.[84] Moreover, when LPN/LVNs work with higher numbers of HPRD for RNs and NAs (that is, total nurse staff) it appears to reduce delayed or omitted care and increase gross cost savings to Medicare.[85] We believe that establishing national, numerical standards of direct care hours will improve safety and quality in many LTC facilities. By creating a consistent Federal floor for staffing expectations, we will better define the minimum number of care hours residents should receive to protect health and safety, while also facilitating strengthened oversight and enforcement.

As an example, when establishing the proposed HPRD level of 0.55 for RNs and 2.45 for NAs, we note that the minimum number of RN hours (that is 0.55 HPRD) provided in a facility that has 100 residents and runs an 8-hour shift per 24 hours, would require a total of 55 RN hours per 24 hours.[86] In other words, at least two RNs on staff each 8-hour shift, plus a third RN for one shift, would be necessary in this scenario although no per shift minimum is being established in this rule. Similarly, the minimum number of NA hours (that is 2.45 HPRD) provided in a facility that has 100 residents and runs an 8-hour shift per 24 hours will require at least a total of 245 NA hours per 24 hours.[87] In other words, at least 10 NAs on staff each 8-hour shift, plus a third NA for one shift would be necessary in this scenario although no per shift minimum is being established in this rule.

These proposed levels for hours of care would establish the minimum nurse staffing levels needed to provide safe and high-quality nursing services to each resident per day. We underscore that these standards reflect only the absolute minimum floor adjusting for the average acuity across all LTC facilities, and the required hours of nursing care may be greater but never lower than the proposed minimum standards, if the acuity needs of residents in a facility requires a higher level of care. Additionally, the proposed staffing levels require all facilities to meet at least this minimum floor, even if the facility has below average acuity, given that resident population can shift more rapidly than staffing plans; most facilities have either an average acuity or higher of resident population; and as noted above, the evidence can also support a higher range of staffing thresholds.

Notably, we are proposing to specify HPRD for RNs and NAs in the minimum staffing requirement at § 483.35(a) and are not proposing a total nurse staffing level under which facilities have the flexibility to decide between types of licensed nurses to meet the minimum requirement. We have taken this approach given the evidence that shows a strong positive association between RN staffing levels and safety and quality, as well as NA staffing levels at higher HPRDs. Literature evidence also indicates that the increased presence of RNs in nursing facilities would help address several issues.

First, research evidence suggests that greater RN presence has been associated with higher quality of care and fewer deficiencies. Second, it has been reported in the literature that where standards provide flexibility as between types of licensed nurses (that is, do not specify RN hours), LPN/LVNs may find themselves practicing outside of their scope of practice partly because there are not enough RNs providing direct patient care and supervision of LPN/LVNs. The specificity of this approach would increase the number of hours per day that a LTC facility must have RNs in the facility and would alleviate concerns about LPN/LVNs engaging in activities outside their scope of practice in the face of resident need during times when no RN is on site (80 FR 42168, 42200). Moreover, to prevent a high rate of unusual patient safety events, the National Academy of Medicine (NAM) (formerly the Institute of Medicine (IOM)) suggests having adequate staffing levels, specifically NAs, who provide most of the care to nursing home residents.[88] In addition, our proposal,

[81] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare and Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[82] *https://data.cms.gov/provider-data/dataset/4pq5-n9py.*

[83] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare &and Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[84] Bowblis J.R. (2011). Staffing ratios and quality: an analysis of minimum direct care staffing requirements for nursing homes. *Health services research, 46*(5), 1495–1516. *https://doi.org/10.1111/j.1475-6773.2011.01274.x.*

[85] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[86] 100 residents × 0.55HPRD = 55 RN hours for 24 hours; or 18 RN hours/8-hour shift; that is ~2 RNs.

[87] 100 residents × 2.45HPRD = 245 NA hours for 24 hours; or 81 NA hours/8-hour shift; that is ~10 NAs.

[88] Institute of Medicine (US) Committee on the Work Environment for Nurses and Patient Safety. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Edited by Ann Page, National Academies Press (US), 2004. doi:10.17226/10851.

which focuses on sufficient numbers of nursing staff, does not contemplate staffing levels for non-nursing staffing because nursing staff are most critical to ensuring minimum standards of care, and there is insufficient information on non-nurse staffing levels in the PBJ System and other available data sources that limits our efforts to examine staffing requirements for non-nurse staff at this time. We solicit comment on the need to allow for substitution, such as substituting LPN/LVNs for NAs, in extraordinary cases and specifically what extreme circumstances would appropriately allow for such substitution.

As noted, based on the findings reported in the 2022 Nursing Home Staffing Study, information gathered through the FY2023 SNF PPS RFI, listening sessions, assessment of the PBJ System data, and review of the literature evidence, we are proposing individual minimum staffing levels at 0.55 HPRD for RNs and 2.45 HPRD for NAs. In establishing this proposal, we considered the context of substantial cost that the proposed policy may impose on LTC facilities, especially those with limited resources that may face difficult decisions in terms of how to allocate funding and resources (see Regulatory Impact Section for more detail). Likewise, the evidence from the 2022 Nursing Home Staffing Study supports the proposed minimum staffing level for RNs and NAs for improving safety and leading to higher quality care. As such, we are proposing minimum nurse staffing standards for these two types of nursing staff that we believe are reasonable and creates meaningful, positive impact on resident quality and safety. These standards will especially help ensure all facilities reach acceptable levels of safety and quality care, working in tandem with CMS' other quality improvement programs that focus on raising performance beyond minimum requirements.

The proposed minimum nurse staffing standards would create broadly applicable minimum standards at which all residents across all LTC facilities would be at a significantly lower risk of receiving unsafe and low-quality care. LTC facilities would be required to staff above these minimum adjusted baseline levels, as appropriate, to address the specific needs of their unique resident population. This additional staffing should be based at the facility level using the facility assessment and an examination of resident acuity levels.

LTC facilities are also responsible for compliance with other requirements for participation, including but not limited to § 483.24, which requires that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Therefore, we propose to add a new § 483.35(a)(1)(v) to reinforce this standard. Specifically, at § 483.35(a)(1)(v), we propose to specify that compliance with minimum HPRD for RN and NA should not be construed as approval for a facility to have fewer nursing and non-nursing staff than the number of staff with the appropriate competencies and skills sets necessary to assure resident safety, and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at current § 483.70(e)), which we propose to be redesignate as new § 483.71.

The acuity and characteristics of residents in LTC facilities has continued to evolve and change over the years. For example, there are more residents with a psychiatric diagnosis with reports showing that the proportion of residents with schizophrenia increased from 6.5 percent in 2000 to 12.4 percent in 2017.[89] There has also been an increase in the percentage of facilities with an Alzheimer's unit and more residents appear to need assistance with activities of daily living. For example, it was reported that on average 96 percent of residents at the facility level needed assistance with bathing in 2015, compared to the national average of 89 percent of residents in 1985.[90] Also the percentage of residents with bladder incontinence has also increased over the years from 49.3 to 62.1 percent.[3]

Furthermore, there appears to be an increase in the proportion of younger residents, under 65 years of age, in part due to severe mental illness and substance use disorders, who have different needs from the traditional nursing home population.[91] Given the variation in resident acuity and complexity of care required for a facility's unique resident population, facilities must make thoughtful, informed staffing plans and decisions that are focused on meeting resident needs, including maintaining or improving resident safety and quality of life, which will often result in the need for a facility to staff above the minimum nurse staffing requirement. Based on the needs of its resident population, an individual facility may need to maintain levels of HPRD for RN, NA and other staffing that surpasses the proposed minimum nurse staffing HPRD.

This need for increased staff would be evidenced by the facility assessment (§ 483.70(e)) and resident assessments (§ 483.20) which would require facilities to make staffing and care planning decisions that account for resident acuity, physical/cognitive abilities, conditions, diagnoses, etc . . . Compliance with the numerical minimum staffing requirement is necessary but not necessarily sufficient to meet staffing needs for every facility. Later in this proposed rule, we discuss an additional element of this comprehensive proposal, revising the facility assessment requirement at § 483.70(e) which we believe would help avoid the unintended consequence of facilities inappropriately staffing at the minimum staffing requirement.

We note that, as discussed previously, while the 0.55 and 2.45 HPRD standards were developed using case-mix adjusted data sources, the standards themselves will be implemented and enforced independent of a facility's case-mix. In other words, facilities must meet the 0.55 RN and 2.45 NA HPRD standards, regardless of the individual facility's patient case-mix. Based on the October 2021 Care Compare data, we estimate that approximately 6,094 facilities are staffed below a level of 0.55 for RNs, and approximately 9,998 are currently staffed below a level of 2.45 for NAs out of an estimated 14,688 total facilities with complete information. These estimates do not reflect proposed exemptions discussed below. Similarly, we recognize that there are facilities currently staffing at levels greater than or equal to 0.55 RN HPRD (n=8,594) and 2.45 NA HPRD (n=4,690) who would not be directly impacted by this proposed policy at this time. However, staffing should be assessed on an ongoing basis and we emphasize that

[89] M. Barton Laws, Aly Beeman, Sylvia Haigh, Ira B. Wilson, Renée R. Shield, Prevalence of Serious Mental Illness and Under 65 Population in Nursing Homes Continues to Grow. Journal of the American Medical Directors Association,Volume 23, Issue 7, 2022, Pages 1262–1263, *https://doi.org/10.1016/j.jamda.2021.10.020.*

[90] Fashaw, Shekinah A et al. ''Thirty-Year Trends in Nursing Home Composition and Quality Since the Passage of the Omnibus Reconciliation Act.'' *Journal of the American Medical Directors Association* vol. 21,2 (2020): 233–239. *doi:10.1016/j.jamda.2019.07.004.*

[91] Laws, M Barton et al. ''Changes in Nursing Home Populations Challenge Practice and Policy.'' *Policy, politics & nursing practice* vol. 23,4 (2022): 238–248. doi:10.1177/15271544221118315.

the facility must provide adequate nursing care to meet the needs of each resident.

Typical characteristics of LTC facilities that may need to staff up to meet this minimum requirement, based on having current staffing, below the proposed levels are:

- For-profit facilities (compared to government and non-profit facilities).
- Larger facilities.
- Freestanding LTC facilities (relative to hospital-based).
- Facilities that are part of a Continuing Care Retirement Community.
- Facilities with higher shares of Medicaid residents.
- Facilities that are Special Focus Facilities (SFF) or SFF candidates.
- Rural facilities.

We note that the existing statutory waiver for Medicaid NFs, authorized by section 1919(b)(4)(C)(ii) of the Act and implemented at § 483.35(e) for a State to waive the requirements of § 483.35(b) to provide licensed nurses on a 24-hour basis would still be in place for NFs to pursue through the current waiver process. The statutory waiver is discussed further under Section II.B. 3. ''Hardship Exemption from the Minimum Hours Per Resident Day Requirements for RNs and NAs.'' In addition, we propose to add new paragraphs (a)(1)(iii) and (iv) to existing § 483.35 to specify that facilities may be exempted from the minimum HPRD requirement for RNs and NAs using separate criteria, and to indicate the period of time that will be assessed to determine compliance.

At new § 483.35(a)(1)(iii), we propose facilities that are found non-compliant with the HPRD requirement for RNs and NAs and meet certain eligibility criteria may be exempted from the 0.55 HPRD for RNs and/or 2.45 HPRD for NAs requirements. The details of this exemption framework and the specific eligibility criteria are discussed further in section II.B.3. ''Hardship Exemption from the Minimum Hours Per Resident Day Requirements for RNs and NAs.'' of this rule. At new § 483.35(a)(1)(iv), we propose that determinations of compliance with minimum HPRD requirements for RNs and NAs will be made based on the most recent available quarter of PBJ System data submitted in accordance with the requirements at existing § 483.70(p) (''Mandatory Submission of Staffing Information Based on Payroll Data in a Uniform Format'').

We solicit comments on the timeframe used to determine compliance with the minimum HPRD, specifically if the lookback period should be longer, for example 1 year to cover a full certification period, or some other timeframe to ensure the most reliable and realistic assessment of staffing data. We also invite public comments on the following proposals discussed in this section. As highlighted throughout the discussion, we acknowledge multiple avenues for establishing a minimum nurse staffing requirement. Based on the proposed policy presented in this rule, we are seeking feedback regarding whether or not alternative policy options are necessary to meet and maintain acceptable quality and safety within LTC facilities, while balancing a facility's ability to comply and ensure access to care.

In developing the proposed rule, we considered varying staffing models that are available and different approaches we could have adopted for establishing minimum nurse staffing standards. For example, we could have adopted multiple different types of combinations of staffing requirements, such as a four-part requirement (inclusive of a total nurse staffing ratio, RNs, LPN/LVNs, and NAs) or a three-part requirement (inclusive of a total nursing staffing ratio, RNs, NAs or separate standards for RNs, LPN/LVNs, and NAs). We also considered that LTC facilities differed across States in their reliance on LPN/LVNs, which was one of the reasons that we did not set a minimum requirement for LPN/LVNs, in addition to available evidence on LPN/LVN associations with safety and high—quality care. Alternatively, we could have proposed staffing requirements for professionals such as social workers, therapists, feeding assistants and other non—nurse staff in the minimum staffing requirement. However, the HPRD reported in PBJ System data for non-nurse staff were insufficient for use in establishing minimum staffing requirements at this time.

We propose to use HPRD that LTC facilities self-report to CMS and currently reported and auditable in the CMS' PBJ System. However, we recognize that staffing levels can be measured in at least 19 different ways with HPRD being the most frequently used.[92] This includes measuring staffing levels as either full time equivalent per resident, full time equivalent per 100 beds, minutes per resident day, or nursing staff to resident ratios. Alternative minimum staffing policy options could also focus on the need to increase or decrease the number of HPRD or FTEs by nurse staff and/or type or on specifying the number by shift (including day, evening, night, or weekends or over a 24-hour period).

We are soliciting comments on establishing a total nurse staffing standard such as 3.48 HPRD among other alternatives, in place of a requirement only for RNs and NAs, or in addition to a requirement for RNs and NAs. For example, we considered an alternative 3.48 HPRD for the total nurse staffing standard—inclusive of the 0.55 HPRD RN and 2.45 HPRD NA minimum standards—based on the evidence from the 2022 Nursing Home Staffing Study, in addition to other factors discussed throughout the proposed rule. We considered 0.55 HPRD for RNs and 2.45 HPRD for NAs as a part of this alternative total nurse staffing standard based on the evidence from the 2022 Nursing Home Staffing Study and other inputs; 0.55 HPRD for RN and 2.45 HPRD for NA staffing were found to be positively associated with safety and quality. Furthermore, NAs spend the most time providing care to residents by assisting with activities of daily living (for example, feeding, bathing, and dressing). Including an overarching minimum total staffing standard, such as 3.48 HPRD, could enable LTC facilities flexibility on staffing while protecting residents from preventable negative outcomes and would discourage facilities that currently meet the individual RN and NA minimums from decreasing total staffing. We seek comments on the necessity of a total staffing standard and whether a total staffing standard should be adopted alongside individual standards. We specifically seek comment on a standard of 3.48 HPRD among other alternatives.

To maximize the usefulness of the feedback from interested parties on alternative policy options, we emphasize that the recommended policy must support and promote acceptable quality and safety in LTC facilities as the intended goal. We seek comments on the effectiveness of a minimum staffing standard in maintaining quality and safety and ways to minimize administrative burden, both for LTC facilities and for CMS in maintaining and enforcing such a standard and enhance compliance among LTC facilities through the use of automated data collection techniques or other forms of information technology.

We encourage commenters to submit evidence and data to support their recommendations to the extent possible. All comments will be reviewed and analyzed, including consideration for

[92] Clemes, S., Wodchis, W., McGilton, K., McGrail, K., & McMaho, M. (2021). The relationship between quality and staffing in long-term care: A systematic review of the literature 2008–2020. International Journal of Nursing Studies, 122, *https://doi.org/10.1016/j.ijnurstu.2021.104036.*

potential future rulemaking. We welcome comments on the following questions:

- What are the benefits and trade-offs associated with a two-part minimum nurse staffing standard as proposed (inclusive of RNs and NAs) relative to a three-part standard (inclusive of a 3.48 HPRD for total nurse staffing, RNs, and NAs) or a four-part standard (inclusive of a total nurse staffing ratio, RNs, LPNs/LVNs, and NAs)?
- What evidence did States rely on when they adopted their specific minimum nurse staffing standards, both with respect to HPRD and the inclusion or exclusion of certain nursing staff, and what is the rate of compliance?
- Whether we should consider a case-mix adjusted staffing HPRD for each facility to assess compliance with the minimum staffing standards? A case-mix adjusted staffing HPRD would adjust the minimum staffing levels based on the health status of the residents in each facility (known as ''case-mix adjustment''). Specifically, the case-mix adjustment methodology aggregates data from each resident's assessment (the Minimum Data Set (MDS)) to identify the general level of acuity of each facility's residents. The level of acuity is then combined with the facility's self-reported (that is, unadjusted) staffing information to calculate the level of staff the facility has that is equivalent to other facilities.

If we were to adjust the minimum staffing levels based on the health status of the residents in each facility to ensure that staffing levels are adequate to meet the unique needs of the residents in each facility—

- What steps can CMS take to support LTC facilities in predicting what their case-mix adjusted staff might be and hire in expectation of that adjusted staffing level? What resources will facilities need to proactively calculate their existing HPRD for nursing staff, and what may be needed?
- What alternative policies or strategies should we consider to ensure that we enhance compliance, safeguard resident access to care, and minimize provider burden? Are there are other alternative policy strategies we should consider?

b. Registered Nurse (§ 483.35(b)(1))

The existing LTC facility staffing regulations require an RN to be on site 8 consecutive hours a day for 7 days a week (§ 483.35(b)(1)).[93] This requirement serves as a minimum to protect the health and safety of LTC facility residents. In other words, an RN is required to be onsite for a total of 8 consecutive hours out of 24 hours a day. The LTC facility may decide to allocate all 8 consecutive hours of RN time to one day shift or an evening shift for a 24-hour day, similarly to the HPRD proposed for RNs.

However, to prevent avoidable patient safety events, some organizations have recommended higher recommendations to each RN staffing levels. For example, in 2022, the National Academies of Science, Engineering, and Medicine (NASEM) published a report that recommended direct-care RN coverage 24 hours a day, 7 days a week.[94] Like NASEM, we are concerned that even with minimum HPRD standards, these residents are at risk for preventable safety events when there is no RN on site, particularly during evenings, nights, weekends, and holidays. Therefore, to avoid placing LTC facility residents at risk of preventable safety events due to the absence of an RN, we are proposing to revise § 483.35(b)(1) to require LTC facilities to have an RN onsite 24 hours a day, 7 days a week.

LTC facilities provide care for residents with increasing medically complex and acute health conditions that require substantial resources and care. This care is provided or supervised by an RN. In the FY 2016 final rule, we indicated that CMS was proposing changes to the LTC facility participation requirements to ensure that LTC facilities are providing quality and safe care to medically complex residents among others (81 FR 68688). We noted that not only has the acuity of the resident population generally increased, but there has also been a dramatic increase in the number of residents recovering from an acute episode of major surgery, injury, or illness (sub-acute resident population).

Medicare payment policy has also contributed to higher acuity levels in LTC facilities. After Medicare implemented the prospective payment system for hospitals in 1983, there were shorter hospital stays for Medicare beneficiaries and increased funding for post-acute stays in LTC facilities (80 FR 42168, 42174–42175). This payment policy resulted in a growing sub-acute resident population in LTC facilities that would have previously experienced longer hospital stays. Also, with the increase in alternatives to LTC facilities, such as assisted-living facilities and home care, LTC facilities are caring for more dependent residents who require more complex basic medical care and rehabilitative services. In addition, LTC facilities are caring for a significant number of residents with dementia, depression, or other behavioral health issues. LTC facilities today have even been referred to as ''mini-hospitals.'' [95]

While RNs and LPNs/LVNs appear to provide some similar nursing services, such as administering medications, there are crucial differences. Compared to LPNs and LVNs, RNs' scope of practice is broader and they receive more education.[96] Most importantly, RNs practice independently and are qualified to conduct clinical nursing assessments, whereas LPNs and LVNs require an RN or a physician's supervision. This is a critical feature in the RN scope of practice given the higher acuity of today's LTC facility resident population and the need to properly clinically assess residents to ensure they are receiving the appropriate care. Also, it has been reported in the literature that LPN/LVNs may find themselves practicing outside their scope of practice when there is not sufficient RN staffing in a facility to provide direct or supervised resident care (80 FR 42168, 42200). Thus, we are also proposing that the RN be available to provide direct resident care around the clock.

For several decades, studies and gray literature materials other than traditional research publications, such as opinion pieces, advocacy materials, and non-statistically rigorous research published by government agencies have recommended an RN onsite 24–7 in LTC facilities for similar reasons. As noted previously in this proposed rule, the 2022 NASEM report, recommended that LTC facilities have 24 hours a day, 7 days a week RN onsite coverage. NASEM noted that most LTC facilities provide care for both short-term residents who require rehabilitation or subacute care and long-term care for residents. While the acuity of short-term residents would vary greatly depending upon their reason for admission and condition, NASEM noted that the long-term care residents typically have multiple chronic conditions that require professional nursing surveillance to

[93] 42 CFR 483.35, *https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.*

[94] National Academies of Sciences, Engineering, and Medicine. 2022. *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff.* Washington, DC: The National Academies Press. *https://doi.org/10.17226/26526.*

[95] Three challenges of long-term care (LTC) nursing. Health. Accessed at *https://www.wolterskluwer.com/en/expert-insights/three-challenges-of-longterm-care-ltc-nursing.* Published on May 5, 2015. Accessed on February 13, 2023.

[96] Jividen, S. *RN* vs. *LPN. Nurse.org.* Accessed at *https://nurse.org/resources/rn-vs-lpn/.* Published on July 15, 2021. Accessed on February 13, 2023.

monitor the residents for changes that might require hospitalization or potentially be life-threatening.[97] As noted previously in this rule, it is the RN that has the education, training, and qualifications to conduct clinical nursing assessments. The report also suggested that there be additional RN coverage when needed and that the DON not be counted towards this requirement.

In the 2016 LTC facility final rule,[98] we noted that several commenters, including the Center for Medicare Advocacy and the California Advocates for Nursing Home Reform, recommended that LTC facilities have 24-hours RN onsite coverage. These commenters argued that 24-hours RN coverage was necessary due to the increased acuity in residents and that expert nursing skill is needed to ''anticipate, identify and respond to changes in [a resident's] condition,'' as well as for the residents to have appropriate rehabilitation services and the best chance for being discharged home in a safe and timely manner (80 FR 68754). Other commenters noted that RN staffing was essential for safe and effective resident care.[99] While we agreed with the commenters on the importance of staffing, and noted that due to their education and licensure, RNs possess the skills that are ''essential for timely assessment, intervention and treatment,[100] we did not establish a minimum nursing staff standard at that time for the reasons noted in the 2016 final regulation. Instead, at § 483.35, we finalized an approach that required the LTC facility to have sufficient nursing staff to assure safety and well-being of each resident as determined by resident assessments and individual plans of care and considering the number and acuity of diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e). Among other reasons, we did not propose a 24-hour RN onsite requirement due to lack of sufficient data including PBJ System data. As discussed previously in this proposed rule, we did not yet have the data from the PBJ System or another reliable source upon which to base a minimum staffing requirement. We now also have the Abt study discussed above that demonstrated the importance of RNs to the quality-of-care residents receive. Others, including professional nursing organizations, also contended that the requirements should be focused on resident acuity and the competencies and skill sets of the nursing staff than a specific numerical requirement for categories of staff (80 FR 42168, 42200 and 42201). We were also concerned that some LTC facilities, especially those in rural and underserved areas, might find complying with such a requirement especially challenging (81 FR 68694, 68752, 68755).

We also heard these same concerns reiterated in the FY 2023 SNF PPS RFI comments and the interested parties listening sessions discussed previously. These commenters noted that RNs, by the virtue of their education and training, have diagnostic and assessment skills that other types of nurse staff do not. They noted that LTC facilities have populations with the highest needs and complex medical issues and the availability of RNs for resident assessments is necessary and could prevent avoidable resident hospitalizations. Based on comments received in the FY 2023 SNF PPS RFI, NASEM's recommendations, and other gray and peer-reviewed literature, we propose that all LTC facilities must have an RN onsite 24 hours a day, 7 days a week at § 483.35(b)(1).

An existing statutory waiver for Medicare SNFs, set out at section 1819(b)(4)(C)(ii) of the Act and implemented at § 483.35(f), permits the Secretary to waive the requirements of § 483.35(b) to provide the services of a RN for more than 40 hours a week, including the director of nursing. This waiver would still be in place for SNFs to pursue through the current waiver process. Facilities would also use this process to pursue a waiver of the 24 hours a day, 7 days a week requirement. However, we discuss certain criteria that may exempt a LTC facility (SNF or NF) from meeting the proposed HPRD levels for RNs and NAs specifically established in § 483.35(a)(1)(i) and (ii) in section III.B.4 of this rule. We welcome comments regarding our proposed requirements for each LTC facility to have an RN on site 24 hours a day, 7 days a week that is available for direct resident care.

In addition to our proposed 24-hour, 7 days a week requirement for an RN, we continue to maintain a separate requirement for the DON. All LTC facilities must designate an RN to serve as the DON on a full-time basis (§ 483.35(b)(2)). The current rule stipulates that the DON can serve as a charge nurse only if the facility has an average daily occupancy of 60 or fewer residents (§ 483.35(b)(3)). Since the DON must be an RN, the DON is included in the proposed nurse minimum staffing requirements as an RN. All RNs with administrative duties, including the DON, should be available for direct resident care when needed. However, the DON, as well as other nurses with administrative duties, would probably have limited time to devote to direct resident care. We are concerned that for some LTC facilities having the DON as the only RN on site might be insufficient to provide safe and quality care to residents. This concern was also expressed in the NASEM 2022 publication discussed previously, in which the NASEM recommended that the DON not be counted in the requirement for an RN 24 hours, 7 days a week.[101] All comments regarding these questions will be reviewed and analyzed, including consideration for potential future rulemaking.

We welcome comments on the following questions:

- Does your facility, or one you are aware of, have an RN onsite 24 hours a day, 7 days a week? If not, how does the facility ensure that staff with the appropriate skill sets and competencies are available to assess and provide care as needed?
- If a requirement for a 24 hour, 7 day a week onsite RN who is available to provide direct resident care does not seem feasible, could a requirement more feasibly be imposed for a RN to be ''available'' for a certain number of hours during a 24 hour period to assess and provide necessary care or consultation provide safe care for residents? If so, under what circumstances and using what definition of ''available''?
- Should the DON be counted towards the 24/7 RN requirement or should the DON only count in particular circumstances or with certain guardrails? Please explain why or why not.
- Are there alternative policy strategies that we should consider to address staffing supply issues such as nursing shortages?

2. Administration (§ 483.70)

We believe that a comprehensive approach to establishing staffing requirements is necessary to ensure that facilities are making thoughtful, informed staffing plans and decisions to support the health, safety, and well-being of residents. In particular, we want to avoid unintended consequences of establishing a minimum nurse

[97] FN #93, NASEM, p. 58.

[98] Medicare and Medicaid Programs; Report of Requirements for Long-Term Care Facilities. 81 FR 68688. Published on October 4, 2016.

[99] FN #24, p. 68754.

[100] FN #24, p. 68754.

[101] National Academies of Sciences, Engineering, and Medicine. 2022. *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff, Recommendation 2B.*

staffing requirement that could lead to a regression by those facilities currently staffing above the staffing requirement or facilities only staffing at the minimum level proposed without considering whether resident acuity or resident census, requires additional staffing above that floor. It is our expectation that LTC facilities will consider their capabilities and capacity, as well as the number, acuity, and diagnoses of their residents when developing staffing schedules.

As previously discussed, in 2016, we released a final rule that revised the requirements that LTC facilities must meet to participate in the Medicare and Medicaid Programs.[102] As part of those revisions, we finalized revisions at § 483.70(e), *Administration,* to require facilities to conduct, document, and annually review a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. This facility-wide assessment requires LTC facilities to determine adequate staffing type and level based on the number of residents, resident acuity, range of diagnoses, the content of care plans, and other factors. LTC facilities are also required to address and document in their facility assessments their resident population (that is, number of residents, overall types of care and staff competencies required by residents, and cultural aspects), resources (for example, equipment, and overall personnel), and a facility-based and community-based risk assessment.

While we assumed when we finalized the 2016 rule that most LTC facilities already conducted some type of facility assessment of the resident population and resources required as part of their normal strategic planning, our revisions aimed to ensure that facilities had a formal process for consistently conducting and documenting these assessments and keeping them up-to-date. The formal facility assessment process requires facilities to make thoughtful, person-centered staffing plans and decisions focused on meeting resident needs that may help improve the safety of residents. We believe this approach will help facilities comply with the requirement to have sufficient staff, which is investigated during surveys.

One of the goals of the 2016 revisions to the LTC facility participation requirements for health and safety was to ensure that our regulations align with current clinical practice and allow flexibility to accommodate multiple care delivery models to meet the needs of diverse populations that receive services in these facilities. As noted previously, given the limitations of the PBJ System data in 2016, we enacted a competency-based approach in the 2016 final rule, that focused on achieving the statutorily mandated outcome of ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The facility assessment requirement was central to the revised 2016 LTC facility participation requirements, and was intended to be used by the facility for multiple purposes, including, but not limited to, determining adequate staffing and other resources, establishing a Quality Assurance and Performance Improvement (QAPI) program, and conducting emergency preparedness planning.

Our expectation was that the application and development of the facility assessment requirement and competence-based staffing decisions would involve every service provided by a LTC facility and apply to all staff, including the interdisciplinary team. For example, a facility that provides dementia care would need to ensure that it has a sufficient number of staff with the necessary skill sets and competencies to care for individuals living with dementia. In addition, CMS intended for facilities to use the facility assessment as a resource and planning tool for both short-term (day-to-day) and long-term (strategic) purposes.

As part of the FY2023 SNF PPS proposed rule, we sought public input on how the facility assessment requirement should impact the minimum staffing requirement (87 FR 22720). Many commenters suggested that the facility assessment requirement should be used to complement the minimum staffing requirement and to determine any additional nursing staff that the facility needs, based on the acuity and needs of its resident population. Other commenters shared concerns that the Federal regulations established in 2016 requiring nursing homes to conduct a facility self-assessment have never been adequately enforced or surveyed.

As discussed earlier in this proposed rule, the recent 2022 Nursing Home Staffing Study [103] included in-person interviews and surveys with facility leadership, direct care staff, and residents and their family members to better understand the relationship among nurse staffing levels, staffing mix, and the safety and quality of resident care. During interviews, staff respondents (RNs, LPNs, NAs) were asked to identify the number of residents that they could provide with quality and safe care and to recommend minimum staffing requirements. Respondents consistently noted that resident acuity was more important than the actual number of assigned residents in determining whether they could provide quality and safe care based on their staffing assignments. Some respondents suggested minimum staffing requirements in terms of the number of residents per shift/unit, accounting for acuity, that they could safely manage and reported that their usual shift/unit is frequently short-staffed. Some respondents also reported concerns about a potential minimum staffing requirement being set too low, fearing that administrators will understaff shifts, or that the minimum will become the maximum.

Furthermore, we share the concern that there may be facilities who currently exceed the proposed minimum staffing level and could potentially be perversely incentivized to lower their staffing levels to the required minimum staffing levels, rather than continuing to staff above that level to meet the unique care needs of their residents. Therefore, we underscore that in addition to meeting the proposed minimum staffing levels, the facility assessment must continue to be used to determine the necessary resources and staff that the facility requires to care for its residents, regardless of whether or not the facility is staffed at or above the new minimum staffing requirement. Furthermore, we emphasize that a LTC facility's staffing decisions should be based on the specific needs of its resident population and not motivated by cost-savings. Thus, while each LTC facility must comply with the minimum nurse staffing requirements set forth at § 483.35(a), unless the facility qualifies for a hardship exemption under § 483.35(g), the facility must also provide sufficient staff (RNs, licensed nurses, and NAs) to provide nursing care to all residents in accordance with the residents' assessments and individual care plans (§ 483.35—introductory statement). Lastly, we note that this proposed rule is not intended to, and would not preempt the applicability of any State or local law providing a higher standard (in this case, a higher HPRD ratio or an RN

[102] *https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities.*

[103] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare and Medicaid Services *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

coverage requirement in excess of one RN on site 24-hours per day, 7 days a week) than would be required by these proposed rules. To the extent Federal standards exceed State and local minimum staffing standards, no Federal pre-emption is implicated because facilities complying with Federal law would also be in compliance with State law. We are not aware of any State or local law providing for a maximum staffing level. However, we note that this proposed rule is intended to and would preempt the applicability of any State or local law providing for a maximum staffing level, to the extent that such a State or local maximum staffing level would prohibit a Medicare and Medicaid certified LTC facility from meeting the minimum HPRD ratios and RN coverage levels proposed in this rule.

To ensure that facilities are utilizing the facility assessment as intended, we are proposing to redesignate the existing requirements for the facility assessment to its own standalone section from § 483.70(e) to proposed § 483.71. We note that we are also proposing technical changes throughout the CFR to replace references to § 483.70(e) with § 483.71 based on this proposed change. Given the importance of the facility assessment requirement and the multiple program ways in which the assessment may be used to inform a facility's decision-making and planning, we believe that the requirements should be set out as a standalone section rather than in the Administration section. In addition, while the responsibility to implement and utilize the facility assessment to inform facility operations belongs to the facility's administrator and governing body, we acknowledge that a multitude of facility leadership and management contribute to the development of the assessment given its importance and broad applicability.

In addition to redesignating (this is, relocating or moving) the existing requirements to a standalone section, we are also proposing clarifications throughout the section to further specify what the facility assessment must be used for. We propose to redesignate the stem statement for current § 483.70(e) to the stem statement for proposed § 483.71. Existing paragraphs § 483.70(e)(1) through (3) identify the key elements of the facility assessment and specify the considerations that the assessment must account for, including the facility's resident population, resources, and the facility and community-based risk assessment which is required to complete as part of the facility's emergency planning. This includes using their assessment of resident needs to determine the competencies and skill sets their staff needs to provide safe and quality care for the residents. The LTC facility should also use the information from the facility assessment to determine their training needs for its staff. We propose to redesignate § 483.70(e)(1) through (3) as proposed § 483.71(a)(1) through (3), respectively. We note the discussion of the proposed revisions follows the organization of the requirements as presented in the new standalone section we are proposing at § 483.71.

At new paragraph § 483.71(a)(1)(ii), we propose to clarify that facilities would have to address in the facility assessment details of its resident population, including the care required by the resident population, using evidence-based, data driven methods that consider the types of diseases, conditions, physical and behavioral health issues, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under existing § 483.20 ''Resident Assessment.''. Specifically, we propose to revise this paragraph by specifying the ''use of evidence-based, data driven methods'' and create a link to the requirements for the resident assessment. Facilities are expected to update their facility assessment as needed, no less than annually, using evidence-based, data-driven methods, that consider the needs of their residents and the competencies of their staff. For example, facilities need to be able to describe residents' acuity levels in order to understand the care and services required, and we would expect that they refer to data sources such as the resident assessments; comprehensive care plans; MDS; RUG–IV categories, if available; or, other resident acuity tools. Assessing acuity levels and effectively using MDS and discharge planning are also an important part of ensuring that an individual can return to the community whenever possible in the least restrictive environment.

In addition, existing regulations at § 483.40 require LTC facilities to provide each resident with the necessary behavioral health care and services for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with his or her comprehensive assessment and plan of care. Hence, we also propose to revise this paragraph to add ''behavioral health issues'' to clarify that LTC facilities must consider their residents' physical and behavioral health issues. We are also concerned with issues of inaccurate MDS coding of residents with a diagnosis of schizophrenia and are taking action to reduce the inappropriate use of antipsychotics without clinical indication in nursing homes.[104] Therefore, we believe these revisions are necessary to ensure that facilities are providing residents with appropriate services and care for behavioral health. At new § 483.71(a)(1)(iii), we propose to add ''and skill sets'' so the requirement reads, ''(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population.'' At new § 483.71(a)(3), we propose to add a cross-reference to the existing requirements for facilities to conduct a facility and community-based risk assessment as part of their emergency planning resources.

At new § 483.71(a)(4), we propose to require facilities to include the input of facility staff, including but not limited to categories such as nursing home leadership, management, direct care staff and their representatives, and staff providing other services. A comprehensive assessment of what resources are required for a LTC facility to provide safe care for its resident population requires the input from facility staff familiar with all of its essential services. Nursing staff working in facilities can provide information to facility management regarding their caseload and how many residents they believe they can safely provide quality care to on a daily basis. Nursing staff are also familiar with the unique needs of their resident population and can speak to the staffing needs at both a shift and unit level.

In addition, direct care employee representation in the facility assessment is critically important to securing an accurate analysis of staffing needs required to ensure resident health and safety. Direct care employees and their representatives are uniquely positioned to assess and communicate what staffing competencies and levels, as well as equipment and other resources are needed to provide appropriate care. These individuals have a unique understanding of the resident population's health needs because of their on-the-ground knowledge of residents' care needs and facility operations. As examples, direct care employees have distinct perspectives into what additional training is needed to manage increased acuity in resident

[104] *https://www.cms.gov/files/document/qso-23-05-nh.pdf.*

needs; what ethnic, cultural, and religious factors are critical to the provision of culturally competent resident care; and how health information technology may be better leveraged to deliver consistent, quality care according to resident preferences.

Input into the facility assessment from any authorized representatives of direct care employees serves several important functions. Such representatives may sometimes be better positioned to directly communicate about facility conditions and the needs of the resident population on behalf of direct care employees who may fear retaliation from their employer. There may also be circumstances where direct care employees are not fluent in English or not familiar with translating observations into resource categories and want a trusted representative to enable open and effective communication in the facility assessment. Alongside direct care employees, their representatives may also help ensure facility assessments are up-to-date and used to inform facility staffing.

Representatives of direct care employees may take different forms. One scenario of representation may involve union workplaces where employees have designated a union representative, such as an employee or third-party elected local union representative, business agent, or safety and health specialist. Representation may also arise in workplaces without collective bargaining agreements where at least one employee or a subset of employees have designated a representative from amongst themselves or a third-party worker advocacy group, community organization, local safety organization, or labor union to serve as their representative in a facility assessment. For example, employees may choose to authorize a union safety and health specialist to help compile staff observations regarding unmet training needs or communicate safety concerns regarding outdated medical equipment, which they may not otherwise feel comfortable sharing as part of their direct reflections on resident needs.

These benefits of enabling the participation of direct employee representatives are consistent with the demonstrated positive association between union representation and resident well-being. According to a recent study, resident mortality and worker infection rates were lower in nursing homes with union representation compared to those without; specifically, the study found unions were associated with 10.8 percent lower resident COVID–19 mortality rates and 6.8 percent lower worker infection rates.[105] We are soliciting public comments on additional studies and data that demonstrate the benefits of the participation of direct employee representatives in the facility assessment process.

Other staff, including but not limited to those in food and nutrition, pharmacy, and facility services, could provide vital information on essential services and resources required to care for the resident population. If the LTC facility provides other services including but not limited to physical therapy or dialysis, it should include input from staff familiar with these services as well. A comprehensive assessment of what resources are required for a LTC facility to provide safe care for its resident population requires the input from facility staff familiar with all of its essential services. We encourage LTC facilities to include the input of not only those personnel from the specifically mentioned areas in the proposed requirement, but also of staff from all areas and their representatives that provide essential services or resources for residents. We request comments on the operational challenges or burdens of this provision as well as how CMS can best provide oversight of this proposed requirement.

We propose at new § 483.71(b)(1) to require facilities to use the facility assessment to inform staffing decisions to ensure appropriate staff are available with the necessary competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). This requirement will help to address some outstanding concerns due to limitations in the PBJ System. While PBJ System data has allowed for additional insight into the staffing levels of facilities, there remain some limitations as to what that data can tell us regarding how facilities are staffed. For example, PBJ System data cannot give us insight into how different resident units are staffed. There are some units in LTC facilities that require higher levels of care based upon the resident acuity, such as memory care or ventilator units. PBJ System data also does not provide information regarding how different shifts are staffed within a LTC facility. The Government Accountability Office, HHS, and OIG have raised concerns related to inadequate staffing in LTC facilities on the weekends and at night.[106] [107] The new requirement at § 483.71(b)(1) will help address that.

In addition, we propose at new § 483.71(b)(2) to require facilities to use the facility assessment to assess the specific needs for each resident unit in the facility, and to adjust as necessary based on any significant changes in the resident population. Facilities would also be required, at new § 483.71(b)(3), to consider the specific staffing needs for each shift, such as day, evening, night, weekends, and to adjust as necessary based on any significant changes to the resident population.

We propose at new § 483.71(b)(4) that LTC facilities would have to use their facility assessment to develop and maintain a staffing plan to maximize recruitment and retention of nursing staff. This staffing plan requirement is consistent with the aims President Biden articulated in the April 2023 ''Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers''.[108] That E.O. directs the Secretary of HHS to consider actions to encourage LTC facilities to reduce nursing staff turnover.[109] This action may help improve quality in LTC facilities since literature evidence suggests that decreases in quality are associated with even a low-to-moderate increase in RN turnover.[110] This E.O. also directs the Secretary to consider additional actions to improve retention of nursing staff by advancing efforts to measure and adjust payments based on staff turnover.[111] For LTC facilities to not only comply with both the current and proposed staffing requirements in this rule but also to achieve the E.O.'s goal of increasing access to higher quality care for LTC facility residents and supporting LTC facility nursing staff, it would be necessary for these facilities to be able to recruit and retain

[105] Dean, A., McCallum, J. et al. Resident Mortality And Worker Infection Rates From COVID–19 Lower In Union Than Nonunion US Nursing Homes, 2020–21. April 20, 2022. *https://doi.org/10.1377/hlthaff.2021.01687.*

[106] Additional Reporting on Key Staffing Information and Stronger Payment Incentives Needed for Skilled Nursing Facilities, July 2021, GAO–21–408, *https://www.gao.gov/assets/gao-21-408.pdf.*

[107] CMS Use of Data on Nursing Home Staffing: Progress and Opportunities To Do More, March 2021, OEI–04–18–00451, *https://oig.hhs.gov/oei/reports/OEI-04-18-00451.asp.*

[108] *Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers.* White House. Accessed at *https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/.* Published on April 18, 2023. Accessed on April 19, 2023.

[109] FN #107, Section 2(b)(ii).

[110] Castle, Nicholas G, and John Engberg. ''Staff turnover and quality of care in nursing homes.'' Medical care vol. 43,6 (2005): 616–26. doi:10.1097/01.mlr.0000163661.67170.b9.

[111] FN #107, Section 2(b)(ii).

sufficient numbers of nursing staff with the appropriate education, training, competencies, and skill sets. To meet these objectives, we believe LTC facilities would need a staffing plan to address staff turnover and consider ways to support staff retention. We have not specified how the staffing plan should be developed or what it must contain because we believe that LTC facilities should have flexibility in developing these plans. However, we encourage LTC facilities to assess the compensation package the facility offers its direct care staff as part of developing the staffing plan. We request comments on the operational challenges or burdens of this provision, as well as how CMS can best provide oversight of this proposed requirement.

We are aware that the COVID–19 PHE has had an impact on the availability of nursing staff in many States, with more facilities needing to use temporary staffing agencies to fill positions, and we want to ensure that facilities have a plan in place should staffing shortages impact their ability to safely provide care to their residents. At proposed § 483.71(b)(5), we are proposing to require facilities to use the facility assessment to inform contingency planning for events that do not require the activation of the facility's emergency plan but do have the potential to impact resident care. For example, facilities should have a contingency plan in place in the event that there is unavailability of direct care nursing staff or other resources needed for resident care.

In summary, we note that the facility assessment works in conjunction with the minimum nursing staff requirements proposed in § 483.35. While we propose to require all LTC facilities (subject to exemptions) to comply with the minimum nursing staffing requirements as set forth at § 483.35(a), those minimum standards are only the beginning. By conducting the facility assessment, the facility will be able to determine what is sufficient staffing, as required by § 483.35(a), for its resident population. The facility assessment will determine not only the sufficient number of staff, but also what competencies and skill sets that staff needs to provide safe care for the resident population. Thus, we emphasize that all LTC facilities must comply with the nursing staff minimums; however, these minimums alone are not targets nor a safe harbor, and facilities may need to staff above the minimum requirements proposed in this rule to satisfy the requirement for sufficient staffing. Conducting the facility assessment will determine not only the number of staff but also the competencies and skill sets that staff must possess to provide safe and high-quality care for the facility's resident population as identified through resident assessments and plans of care as required in existing § 483.35(a)(3).

3. Hardship Exemption From the Minimum Hours per Resident Day Requirements for RNs and NAs

As noted earlier, we are proposing a hardship exemption to the HPRD requirements portion of the minimum staffing standards. The exemption would apply only to the RN and/or NA HPRD requirements and is separate and distinct from existing the existing statutory waiver process that addresses, in particular, overarching RN staffing requirements. While we acknowledge the potential for overlap between the exemption and the waiver (that is, a 24/7 RN may meet the HPRD requirement), each of the minimum staffing requirements independently supports resident health and safety. Therefore, meeting the 24/7 requirement does not also count as meeting the 0.55 RN HPRD and 2.45 NA HPRD and vice versa. Specifically, as discussed elsewhere in this rule, the presence of an RN in a LTC facility on a 24-hour basis improves overall quality of care. Similarly, but separately, a minimum number of RN and NA hours per resident per day improve overall quality of care. Both independently and collaboratively, these requirements support meeting statutory mandates to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care. Both the exemptions and the waiver are discussed in more detail below.

We fully expect that LTC facilities will be able to comply with our proposed standards for nursing staff. However, we recognize that some interested parties have expressed that, in some instances, external circumstances may prevent a LTC facility from meeting our proposed minimum staffing requirements, despite the LTC facility's best efforts. We note, for example, that the COVID–19 PHE exacerbated workforce unavailability issues for some LTC facilities. Some LTC facilities may be challenged in hiring and retaining nursing staff such as registered nurses and certified nursing assistants due to local workforce unavailability, while others may need to improve pay and job quality in order to attract and retain staff, given competition from higher-paying positions or alternate career paths. A 2020 Assistant Secretary for Planning and Evaluation (ASPE) Report found that the COVID–19 PHE contributed to staffing shortages and health care worker attrition, pushing nursing homes to create and implement new recruitment infrastructures, increase wages, and augment benefits to retain staff.[112] As noted in the FY 2023 SNF PPS RFI comments and by interested parties during the CMS hosted listening sessions previously discussed, there is concern from LTC trade associations about whether there is adequate staffing available to meet resident needs and about the feasibility of increasing staffing over a short timeframe given workforce and cost considerations. LTC facility staff interviewees who were part of the qualitative portion of the 2022 Nursing Home Staffing Study [113] also shared concerns about unintended consequences of requiring minimum staffing levels, with fears that some nursing homes could be forced to close if they cannot come into compliance with the minimum requirements.

According to the Bureau of Labor Statistics (BLS), in March 2020, there were 3,372,000 health care staff working in nursing homes and other LTC facilities. This dropped to a low of 2,961,200 in January 2022, a loss of 410,000 staff. This is rebounding, as of June 2023 there are roughly 235,900 fewer health care staff working in nursing homes and other LTC facilities compared to March of 2020.[114] The decline in staff coincided with decreasing LTC facility census beginning in March 2020, as noted below. A January 2023 AHCA/NCAL Report analyzing BLS data notes that other health care sectors (Physician Offices, Outpatient settings, Home Health, and Hospitals) rebounded more quickly than the nursing home sector. This difference in return to employment may have been driven by the comparatively low pay and difficult working conditions for nursing home workers.[115] Commenters to the FY 2023

[112] COVID–19 Intensifies Nursing Home Workforce Challenge, Danny-Brown et al., 2020.

[113] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare and Medicaid Services *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

[114] Bureau of Labor Statistics. *https://data.bls.gov/timeseries/CES6562300001?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true.* Accessed 08/09/2023.*https://data.bls.gov/timeseries/CES6562300001?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true.* Accessed 08/09/2023.

[115] *https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/LTC-Jobs-Report-Jan2023.pdf.*

SNF PPS RFI noted concerns such as, ''We are losing many long-term employees to jobs with better salaries and many of these jobs are not in healthcare. New hires are demanding a higher starting salary as well as large sign on bonuses.'' Several labor and consumer advocacy groups noted competitive wages as a driving factor in staff retention/recruitment. Based on our estimations detailed in section VI. (Regulatory Impact Analysis), of this rule, we expect that a total of 12,639 additional RNs and 76,376 additional NAs will be needed to meet our proposed HPRD requirements, before accounting for any exemptions. In particular, we recognize that lower staffed nursing homes are more likely to be for-profit, larger, rural, and have a higher share of Medicaid residents.[116] Some recent developments, however, should ease staffing difficulties at LTC facilities. According to BLS data, as of January 2022, the number of LTC facility staff has begun to rebound. The number of health care staff working in nursing homes and other LTC facilities as of June 2023 is 3,136,100, with preliminary data indicating continued rebound.[117] Furthermore, beginning in March 2020, facility census declined. By the end of September 2020, nursing home census had declined by an average of nine residents per nursing home, going from an average of 86 residents in January 2020 to 77 residents in September 2020.[118]

We recognize that LTC facility workers—disproportionately women of color—are among the lowest-paid in the country and often have to rely on public benefits despite working complex and demanding jobs. In addition, poor working conditions in LTC facilities have been found to influence the quality of care provided to residents.[119] Investments in the care workforce, including competitive wages, are foundational to helping to retain LTC facility workers and improving health and educational outcomes. Unfortunately, lack of transparency regarding nursing home finances, operations, and ownership impedes the ability to fully understand how current resources are allocated.[120] This obscures evaluation of the industry's ability to absorb the costs of increased staffing and improved working conditions. It is the policy of the Biden-Harris Administration to ensure that the LTC workforce is supported, valued, and well-paid. Indeed, as previously noted, on April 18, 2023, President Biden issued an E.O. on Increasing Access to High Quality Care and Supporting Caregivers. Section 2 of that E.O. addresses Increasing Compensation and Improving Job Quality for Family Caregivers, Early Educators, and Long-Term Care Workers.[121]

To improve working conditions and job quality in federally-funded LTC facility programs, we are encouraging providers to establish incentives to recruit and retain LTC facility workers, help prevent burnout, make it as easy as possible for LTC facility workers to access behavioral health services, and improve the care that individuals receive. The considerations described above, ranging from workforce issues exacerbated by the COVID–19 pandemic, to persistently low wages and benefits, and poor working conditions for the direct care workforce, have informed our approach to the proposed minimum staffing standards, including the 0.55 RN and 2.45 NA HPRD requirements and the proposed exemptions.

The goal of the proposed minimum nursing staffing requirement is to ensure that residents receive safe and high-quality care. It is our intention to balance this goal with the need to ensure access to care, which is an important health and safety consideration. Therefore, CMS is proposing a hardship exemption to the minimum staffing standards, either the 0.55 RN or the 2.45 NA HPRD requirements, or both, proposed at § 483.35(a)(1)(i) and (ii). These proposed exemptions will help to address the current workforce constraints in certain jurisdictions and other potential barriers that some LTC facilities may be experiencing in the wake of the COVID–19 PHE, and to ensure that our proposals do not unintentionally create access issues. Specifically, we propose to re-designate the existing requirements for nurse staffing information at existing § 483.35(g) to a new paragraph (h). We propose at new § 483.35(g) to allow LTC facilities with a verifiable hardship that precludes the LTC facility from achieving or maintaining compliance to be exempt from one or both of the proposed requirements at § 483.35(a)(1)(i) and (a)(1)(ii). Given the complex health needs of LTC residents, to protect resident health and safety, we believe that it is important for exempted LTC facilities to maintain compliance with the 24/7 RN requirement as there are longstanding concerns related to low staffing levels in LTC facilities on weekends and evenings and ongoing RN presence is needed to provide care and monitor resident health. That requirement may be waived only through the waiver process implemented at § 483.35(f) and described below.

In developing our proposed minimum standards for nurse staffing, we recognized that sections 1819(b)(4)(C)(ii) and 1919(b)(4)(C)(ii) of the Act established a waiver process for RN/licensed nurse staffing in LTC facilities. We therefore considered whether or not a similar mechanism would be appropriate for minimum HPRD requirements. We determined, in the same spirit as the existing waiver process, to propose exemptions intended to address underlying workforce unavailability concerns, especially in rural and other underserved areas, while balancing the need for efforts by LTC facilities to recruit staff and improve quality of care. While allowing for these exemptions, we note that each LTC facility must still comply with its statutory and regulatory obligations to have sufficient staff to assure resident safety, and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

These exemptions, while serving a similar purpose, differ from, but are not inconsistent with the waiver for RN and licensed nurse staffing under sections 1819(b)(4)(C)(ii) and 1919(b)(4)(C)(ii) of the Act. The waiver provisions are implemented at § 483.35 (e) and (f). The proposed exemptions will be located at § 483.35(g). We emphasize that the exemptions apply only to the

[116] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Report prepared for the Centers for Medicare and Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf*.

[117] Employment, Hours, and Earnings from the Current Employment Statistics survey (National) *https://data.bls.gov/timeseries/CES6562300001?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true* Accessed 08/09/2023.

[118] Nursing Home Nurse Staff Hours Declined Notably during the COVID–19 Pandemic, with CNAs Experiencing the Largest Decreases Issue Brief (*hhs.gov*), *https://aspe.hhs.gov/sites/default/files/documents/95b3a0f6294c7bb021cfbdc245cd9820/nh-nurse-staff-hours-brief.pdf*.

[119] Perruchoud, Elodie et al. ''The Impact of Nursing Staffs' Working Conditions on the Quality of Care Received by Older Adults in Long-Term Residential Care Facilities: A Systematic Review of Interventional and Observational Studies.'' Geriatrics (Basel, Switzerland) vol. 7,1 6. 28 Dec. 2021, doi:10.3390/geriatrics7010006.

[120] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on the Quality of Care in Nursing Homes. The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff. Washington (DC): National Academies Press (US); 2022 Apr 6. Summary. Available from: *https://www.ncbi.nlm.nih.gov/books/NBK584660/*.

[121] *https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/*.

requirements at § 483.35(a)(1)(i) and (ii) for LTC facilities to meet minimum HPRD staffing requirements for RNs and NAs, while the statutory waiver applies specifically to either RN or licensed nurse services more broadly. Both take into consideration ensuring staff sufficiency to achieve resident safety and well-being, but will be different processes.

The proposed exemption process would be implemented with as little administrative burden on LTC facilities as possible, while also limiting opportunities for inappropriate granting of exemptions; it would also ensure that we are aware of the staffing status of the LTC facility. To obtain an exemption, a LTC facility must demonstrate that it has been unable to recruit appropriate personnel. In addition, the facility remains obligated to ensure the health and safety of facility residents. Therefore, prior to being granted an exemption, the LTC facility must be surveyed to assess the health and safety of the residents. If a LTC facility is found noncompliant with the minimum staffing requirements and does not meet the exclusionary criteria discussed below, the LTC facility's documentation of a good faith effort to hire and retain staff and the LTC facility's documentation of financial commitment must be submitted to CMS. If a LTC facility meets the exclusionary criteria, it will not be considered for an exemption. Such criteria include that the LTC facility must not have failed to submit PBJ System data in accordance with re-designated § 483.70(p), must not be an SFF facility, and must not have been cited by us as having ''widespread'' or ''a pattern of insufficient staffing with resultant resident harm'' or at an ''Immediate Jeopardy to resident health and safety'' level of severity with respect to understaffing within the 12 months preceding the survey during which the facility's non-compliance is identified. We note that the exemptions do not have a separate requirement for the availability of an RN or physician for immediate response, as the exemptions do not relieve the LTC facility of its obligation to have 24/7 RN presence. If a LTC facility were to obtain a waiver of RN/licensed nurse staffing through the existing waiver process, the LTC facility would provide assurances related to having necessary staff availability, among other assurances, as part of that process to obtain such a waiver. We intend to make publicly available information on LTC facilities that have an exemption to the minimum staffing requirements, to assist residents and families in choosing a LTC facility.

To qualify for a hardship exemption, we are proposing that LTC facilities must meet all of the criteria specified at § 483.35(g)(1) through (4). Those criteria include:

1. *Location (proposed § 483.35(g)(1)):* To meet the criterion for location, a LTC facility must either be located:

a. In an area where the supply of the applicable health care staff (either RN, or NA, or both) is not sufficient to meet geographic area needs as evidenced by either a medium (that is, 20 percent below the national average) or low (that is, 40 percent below national average) provider-population ratio for nursing workforce (§ 483.35(g)(1)(i)), as calculated by us, currently by using Bureau of Labor Statistics and Census Bureau data, or

b. Twenty miles or more from the next closest LTC facility, as determined by CMS (§ 483.35(g)(1)(ii)).

2. Demonstrated *Good Faith Effort to Hire and Retain Staff (proposed § 483.35(g)(2)):* To meet the criterion for demonstrated good faith effort to hire and retain nursing staff, a LTC facility must be surveyed and cited as noncompliant with the minimum staffing requirements, while not meeting the exclusionary criteria in section 4. To meet this good faith effort criterion, a LTC facility must have developed and implemented a recruitment and retention plan, as required at proposed § 483.71(b)(5), and must demonstrate that it has been unable, despite diligent efforts including offering prevailing wages, to recruit and retain appropriate nursing staff including NAs. The LTC facility must document recruitment efforts. Such documentation is expected to include job listings in commonly used recruitment forums found online, at American Job Centers (coordinated by the U.S. Department of Labor's Employment and Training Administration), and other forums as appropriate (§ 483.35(g)(2)(i)), job vacancies including the number and duration of vacancies, and offers made (§ 483.35(g)(2)(ii)). The documentation must show that offers are made at prevailing wages or better, as reflected by looking at data on the average wages in the Metropolitan Statistical Area in which the LTC facility is located, and vacancies by industry as reported by the Bureau of Labor Statistics or by the State's Department of Labor (§ 483.35(g)(2)(iii)). This look-back would occur for the time period following when the vacancies occurred. Generally, we would expect that to be a 4- to 6-month period, but could encompass the full year, based on circumstances around the vacancies. Finally, the documentation must include the LTC facility's staffing plan in accordance with proposed § 483.71(b)(4).

3. *Demonstrated Financial Commitment (proposed § 483.35(g)(3)):* To meet the criterion for financial commitment, a LTC facility must be surveyed and cited as noncompliant with the minimum staffing requirements, while not meeting the exclusionary criteria in section 4. Once a finding of noncompliance has occurred, the LTC facility must demonstrate through documentation the financial resources that the LTC facility expends annually on nurse staffing relative to revenue.

4. Exclusions. LTC Facilities must not have failed to submit PBJ System data in accordance with re-designated § 483.70(p), must not have been determined by us to be an SFF facility, and must not have been cited by us as having ''widespread insufficient staffing with resultant resident harm'' or ''a pattern of insufficient staffing with resultant resident harm'', or at an ''Immediate Jeopardy to resident health and safety'' level of severity with respect to understaffing within the 12 months preceding the survey during which the facility's non-compliance is identified.

With respect to location, we are proposing that LTC facilities meet one of two distinct sub criterion to qualify for an exemption. If an LTC meets one of those criteria, they would then be evaluated for fulfilling the remaining criteria listed above.

The first sub criterion applies to LTC facilities that are located in a geographical area that has a shortage of RNs and/or NAs. We define the geographical area as the metropolitan statistical area (MSA) or non-metropolitan statistical area (non-MSA) where the LTC facility is located using data from the U.S. Bureau of Labor Statistics (available at *https://www.bls.gov/oes/current/msa_def.htm*). We determine that there is a ''shortage'' when the MSA or non-MSA has a RN and/or NA to population ratio that is 20 percent below the national average. We provide the definitions of both medium and low provider to population ratio to facilitate comment on the appropriate level to use.

To calculate whether a LTC facility is in an area with a shortage of RNs or NAs, we first use the Care Compare data to identify the State and county where each LTC facility is located. We then combine these data with information from the U.S. Bureau of Labor Statistics (available at *https://www.bls.gov/oes/*

current/msa_def.htm) on the counties in each MSA and non-MSA to identify the MSA or non-MSA where each LTC facility is located. Next, we identify the total number of RNs and NAs in each MSA and non-MSA using the Bureau of Labor Statistic's Occupational Employment and Wage Statistics Query System (available at *https://data.bls.gov/oes/#/home*). Afterwards, we calculate the population for each MSA or non-MSA using population estimates from the United States Census Bureau by summing the population for all counties in the MSA or non-MSA (available at *https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-total.html#v2022*).

Finally, we calculate whether the LTC facility is located in an MSA or a non-MSA with a medium or low provider-to-population ratio by comparing the area's provider-to-population ratio to the average provider-to-population ratio for the United States.

The second location sub criterion is distance to the next closest LTC facility. We are proposing this alternative distance criterion to address potential workforce unavailability within an MSA or non-MSA that overall has adequate workforce availability, but may have pockets within it that are experiencing shortages. We note that MSA and non MSA's may be quite large—for example, one MSA extends from Arlington, VA to West Virginia. Particularly for NAs, the availability, or lack thereof, of public transportation in some areas, and the costs and availability of private transportation can make long work commutes unfeasible. We also recognize there may be access to care concerns should a LTC facility limit admissions or close as a result of staff unavailability within a particular community. In addition to access to care and workforce availability issues, we also recognize the burden on residents and resident families when loved ones have to be located in LTC facilities (or relocated to LTC facilities) at a distance that makes family visitation and participation in care difficult. According to a 2021 study, ''travel time has a substantively and statistically significant negative association on visit probability for all age groups''.[122]

We considered mileage increments from 15 to 50 miles for this alternative criterion. After considering the number of LTC facilities impacted, the overlap of the provider-population ratio, and consideration of travel for both staff and visitors, we determined that 20 miles best addressed these factors compared to a 15-mile increment. As noted below, we welcome comment on this mileage and the factors we should consider in determining an appropriate mileage criterion. We note that all certified nursing homes are geocoded into CMS' online survey and enforcement system. This allows us to easily and accurately calculate the exact distance of LTC facilities to one another. The following chart provides our analyses of distances.

TABLE 3—LTC FACILITIES AT VARIOUS DISTANCES FROM NEXT CLOSEST LTC FACILITY

Distance	# of LTC Facilities without any other LTC facility nearby	% of LTC Facilities without any other LTC facility nearby (percent)
Within 15 miles	852	5.6
Within 20 miles	422	2.8
Within 25 miles	223	1.5
Within 30 miles	155	1.0
Within 35 miles	106	0.7
Within 50 miles	40	0.3

Note: The analysis includes 15,089 LTC facilities (1) active as February 2023 and (2) with non-missing values in latitude or longitude.

There are three exclusions from the exemption criteria. First, LTC facilities must be in compliance with requirements for the submission of PBJ System data. This data is critical to our evaluation of LTC facility staffing. Next, sections 1819(f)(8) and 1919(f)(10) of the Act require us to maintain a SFF program for enforcement of participation requirements for LTC facilities that have been identified as having substantially failed to meet applicable health and safety requirements. We are statutorily-required to survey these LTC facilities once every 6 months. LTC Facilities designated as SFFs have a history of serious quality issues and are included in this program to stimulate improvements in their quality of care. A LTC facility that is designated as a SFF is excluded from receiving an exemption from the minimum HPRD staffing requirements.

Finally, most LTC facilities have some deficiencies, but some LTC facilities have significantly more problems than others (about twice the average number of deficiencies), or have more serious problems than most other LTC facilities (including harm or injury experienced by residents, and a pattern of serious problems that have persisted over a long period of time). An OIG report on adverse events in nursing homes noted that 59 percent of adverse events and temporary harm events were clearly or likely preventable, and attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.[123] Therefore, while we are acknowledging the potential for LTC facility constraints that may create access to care issues and providing for exemptions as it relates to the minimum nursing staffing requirement, we must ensure that LTC facilities are providing safe and acceptable care despite any exemption. Therefore, we propose at § 483.35(g)(4)(ii) that LTC facilities that have been cited for ''widespread insufficient staffing with resultant resident harm'' or ''a pattern of insufficient staffing with resultant resident harm'' or are cited at the immediate jeopardy level of severity with respect to insufficient staffing within the 12 months preceding the survey during which the facility's non-compliance is identified would also not meet the criteria for an exemption from the requirements at § 483.35(a)(1)(i) and

[122] Weimer, David L., Ph.D., Saliba, Debra, MD, MPH, Ladd, Heather, MS, Mukamel, Dana B., Ph.D. ''Who Visits Relatives in Nursing Homes? Predictors of at Least Weekly Visiting'' The Journal of Post-Acute and Long-Term Care Medicine. VOLUME 23, ISSUE 7, JULY 2022. Accessed 6/27/2023 *https://www.jamda.com/article/S1525-8610(21)00831-8/fulltext#%20.*

[123] Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries, Department of Health and Human Services, Office of Inspector General.

(ii). Due to the serious quality issues with these LTC facilities and the intent of the proposed requirement, we believe it is necessary to exclude these LTC facilities from the exemption to maintain the health and safety of residents residing in these LTC facilities.

We emphasize again that the exemptions apply only to the requirements at § 483.35(a)(1)(i) and (ii) for LTC facilities to meet minimum HPRD staffing requirements for RNs and NAs. As such, LTC facilities that qualify for an exemption would still be required to comply with the base requirement at § 483.35(a)(1) that LTC facilities provide services by a sufficient number of [nursing] staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans, as well as the proposed requirement at § 483.35(b)(1), for a LTC facility to provide onsite RN coverage 24 hours a day, 7 days a week; the proposed requirements at § 483.71, to conduct a facility assessment; as well as the multitude of additional minimum health and safety standards for LTC facilities in 42 CFR part 483, subpart B. They are expected to make the effort to hire as many RNs and NAs as necessary to meet resident needs. We note that LTC facilities remain able to apply for a waiver of the RN and licensed nurse staffing requirements, as required by statute and as applicable to the LTC facility. The requirements for such a waiver are set forth in § 483.35 (e) and (f).

Finally, we propose at § 483.35(g)(5) to specify that determinations of eligibility for an exemption are based on paragraphs (g)(1) through (3) and that facilities must provide supporting documentation when requested. At § 483.35(g)(5), we propose that hardship exemptions would be granted for a period of 1-year and could be extended in increments of one additional year, after the initial 1-year period, if the LTC facility continued to meet the exemption criteria without experiencing additional issues that would prevent them from eligibility.

It is our expectation that LTC facilities that qualify for an exemption would make ongoing efforts to increase their capabilities to achieve compliance with the minimum nurse staffing requirement. Likewise, we expect that additional CMS programs, such as the SNF VBP quality measures, will also incentivize facilities to improve staffing at higher levels to both ensure their ability to address resident needs day to day and also to capitalize on incentives that are at their disposal for quality improvements. We solicit comment on these opportunities for hardship exemptions for facilities. We welcome all feedback but are particularly interested in the following:

- What are additional data sources that CMS can use to verify LTC facility hardships based on location or workforce unavailability and shortages or grant hardship exemptions? For example, the review of health professional shortage areas (HPSAs). Which data source or criterion, or combination of data sources or criteria, could accurately indicate hardship while minimizing burden to facilities?
- Is 20 miles the right distance from the next closest LTC facility to warrant a hardship exemption? What distance from the next closest LTC facility results in a hardship for resident families?
- Are there other criteria CMS should consider for a facility to demonstrate good faith effort to hire and retain nursing staff. Should CMS use BLS's median OES data to determine prevailing wage?
- Are there additional approaches to mitigating access to care concerns that CMS should consider without allowing for exemptions to the minimum nurse staffing requirement?
- Are there additional exclusions to the proposed exemptions that CMS should consider to protect resident health and safety? For example, should we exclude candidates for the SFF program from receiving an exemption?
- Is 12 months the right look-back time frame for exclusions? If not, what is the best time frame? Should it be 15 months? Should it be to and including the last recertification survey?
- Are there additional hardships that CMS should consider? If so, how will such considerations support quality care and protect resident health and safety?
- Should CMS provide an exemption for facilities based on financial difficulty/constraints? If so, what would be an appropriate judgment of a LTC facility's financial status and/or financial effort? Considering the Medicaid transparency proposal discussed in this proposed rule, should CMS identify minimum spending thresholds for direct care staff that facilities must meet before being considered for an exemption? Is there a specific spending to revenue threshold that would be appropriate? What type of data and/or data sources can be used to maximize transparency and provide an objective determination?
- Are there additional steps that CMS can take to increase transparency and address staffing shortages? For example, this regulation discusses a proposal to require States to report to CMS on the percentage of payments for Medicaid-covered nursing facility services that are spent on direct care workers and support staff. Are there additional efforts that CMS and facilities can take to promote transparency and accountability related to funding for and supporting staffing?

4. Implementation Timeframe

As discussed, we are proposing a minimum nurse staffing requirement for LTC facilities of 0.55 and 2.45 HPRD by RNs and NAs, respectively. We also propose revisions to the existing RN staffing to require an RN on site 24 hours a day, 7 days a week to provide nursing care to all residents in accordance with resident care plans; and propose revisions to the facility assessment requirement. The adoption of these requirements would improve the safety and quality of care of residents and provide direct care workers with the support needed to provide high-quality care.

We are proposing to implement these proposed requirements in three phases, to avoid any unintended consequences or unanticipated risks to resident care when a facility is developing new policies and procedures necessary to comply with these requirements.

We acknowledge that these proposed requirements would require approximately 79 percent of LTC facilities to increase their staff levels to meet either the RN onsite 24 hours a day, 7 days a week requirement or the minimum RN and NA HPRD requirements to ensure full compliance with the new proposals discussed in the rule.[124] In addition, we anticipate that additional time would be needed to develop revised interpretive guidance and survey processes, conduct surveyor training on the changes, and implement the software changes in the Long-Term Care Survey Process system.

For facilities located in urban areas, we propose that implementation of the final requirements be achieved in three phases, over a 3-year period. Specifically, we propose that—

- Phase 1 would require facilities to comply with the Facility assessment requirements (§ 483.71) 60-days after the publication date of the final rule.
- Phase 2 would require facilities to comply with the requirement for a RN onsite 24 hours a day, 7 days a week (§ 483.35(b)(1)) 2 years after the publication date of the final rule.
- Phase 3 would require facilities to comply with the minimum staffing

[124] Calculations use the October 2021 Care Compare data set that provides each nursing home's average daily resident census and HPRD for each nurse type (that is, RNs, LPNs/LVNs, NAs) using the PBJ System data for 2021 Q2.

requirement of 0.55 and 2.45 HPRD for RNs and NAs respectively (§ 483.35(a)(1)(i) and § 483.35(a)(1)(ii)) 3 years after the publication date of the final rule.

Given that there are fewer rural LTC facilities and a higher percentage of rural LTC facilities have greater distances between neighboring facilities, if a facility was not able to comply with the staffing requirement, it can have a more pronounced impact on access of care. Therefore, we expect that facilities in rural areas will require more time to comply with these requirements, compared to facilities in urban areas.

For facilities located in rural areas, we propose the implementation of the final requirements be achieved in three phases, over a 5-year period. Specifically, we propose that—

- Phase 1 would require facilities to comply with the Facility assessment requirements (§ 483.71) 60-days after the publication date of the final rule.
- Phase 2 would require facilities to comply with the requirement for a RN onsite 24 hours a day, 7 days a week (§ 483.35(b)(1)) 3 years after the publication date of the final rule.
- Phase 3 would require facilities to comply with the minimum staffing requirement of 0.55 and 2.45 HPRD for RNs and NAs respectively (§ 483.35(a)(1)(i) and (ii)) 5 years after the publication date of the final rule.

We note that the final regulations would be effective 60 days following the publication of the final rule in the **Federal Register**. The implementation date for the specific requirements are listed in detail in Tables 4 and 5.

TABLE 4—IMPLEMENTATION TIMEFRAMES FOR FACILITIES IN URBAN AREAS

Regulatory section(s)	Implementation date
Proposed § 483.71	*Phase 1:* 60-days after the publication date of the final rule.
§ 483.35(b)(1)	*Phase 2:* 2 years after the publication date of the final rule.
§ 483.35(a)(1)(i) and (ii)	*Phase 3:* 3 years after the publication date of the final rule.

TABLE 5—IMPLEMENTATION TIMEFRAMES FOR FACILITIES IN RURAL AREAS

Regulatory section(s)	Implementation date
Proposed § 483.71	*Phase 1:* 60-days after the publication date of the final rule.
§ 483.35(b)(1)	*Phase 2:* 3 years after the publication date of the final rule.
§ 483.35(a)(1)(i) and (ii)	*Phase 3:* 5 years after the publication date of the final rule.

We are defining ''rural'' in accordance with the Census definition. ''Rural'' encompasses all population, housing, and territory not included within an urban area.[125] We solicit public comments on whether a different definition should be used. Also, we seek feedback on the following:

- Is the proposed implementation timeframe appropriate? If not, are there any alternative implementation approaches for these requirements?
- Do other underserved communities similarly require longer implementation timeframes?
- To what extent are facilities and State governments planning to phase in, budget for, and prepare for the requirements before they go into effect? Additionally, what are the anticipated effects on resident health and safety that may be associated with these preparations?

We seek input from State Medicaid programs and Medicaid interested parties. Specifically:

- Are there any alternative implementation approaches for these requirements?
- How might the proposed implementation timeframe impact their finances and their ability to recruit in the same labor market?
- How do you foresee potential interactions with other Medicaid initiatives, including implementing access standards on home and community-based services (HCBS)?

Finally, to the extent a court may enjoin any part of the rule, the Department intends that other provisions or parts of provisions should remain in effect. Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

5. Consultation With State Agencies, and Other Organizations

Section 1863 of the Act (42 U.S.C. 1395z), requires the Secretary to consult with appropriate State agencies and recognized national listing or accrediting bodies, and appropriate local agencies, in relation to the determination of conditions of participation for providers of services.

Pursuant to section 1863 of the Act, in addition to publishing the proposed rule we will consult further with the relevant entities following the publication of the proposed rule.

III. Medicaid Institutional Payment Transparency Reporting Provision (§§ 438.72 and 442.43)

A. Background and Scope

Millions of Americans, including children and adults of all ages, need long-term services and supports (LTSS) because of disabling conditions, chronic illness, and other factors. Medicaid allows for the coverage of these services through several authorities and over a variety of settings, ranging from institutional facilities to home and community-based settings. Medicaid programs are required to provide a nursing facility benefit for eligible individuals aged 21 or older. Medicaid programs may also provide other institutional LTSS as optional services, including services in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Medicaid is the largest payer nationally of LTSS. In 2019, 1.5 million Medicaid beneficiaries received nursing facility or ICF/IID services,[126] which accounted for

[125] United States Census Bureau Urban and Rural *https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html.*

[126] Kim, Min-Young, Edward Weizenegger, and Andrea Wysocki. *Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019.* Chicago, IL: Mathematica, July 22, 2022. Accessed at *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-user-brief-2019.pdf.* Disclaimer: This document contains links to non-

Continued

over $61 billion in Medicaid expenditures, or 13 percent of the $478 billion in total Medicaid expenditures during that year.[127] Demand for LTSS, whether delivered in institutional settings or in the home, is expected to continue rising due to the growing needs of the aging population.[128] [129]

As discussed in the section on Minimum Staffing Standards (section II. of this proposed rule), anecdotal, quantitative, and qualitative evidence indicates that consistent, adequate direct care nurse staffing is vital to residents' health and safety. Through our regular interactions with State Medicaid agencies, provider groups, and beneficiary advocates, we have observed that all these interested parties routinely express the concern that chronic understaffing and high rates of worker turnover of direct care workers in Medicaid-participating nursing facilities and ICF/IIDs make it difficult to ensure access to high-quality institutional services for people with disabilities and older adults. In addition to direct care nursing staff, other types of direct care workers—such as physical therapists or feeding assistants—provide long-term care services and supports (including, if applicable, components of active treatment as defined at § 483.440) to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Additionally, direct care workers play a critical role in helping some residents develop the daily living skills needed to transition out of facilities and back to the community, as well as with assessing individuals' readiness for discharge and assisting with discharge planning. Also critical to residents' quality of life and quality of care are support staff who maintain the physical environment of the care facility or provide other supports to residents, such as housekeeping or transportation.

Understaffing in nursing facilities and ICF/IIDs can reduce the efficiency of Medicaid payment for services, most clearly when the payment methodology is based on the actual cost of delivering services and such costs are increased due to reliance on overtime and temporary staff, which can have higher hourly costs than non-overtime wages paid to permanent staff. Further, understaffing can reduce quality of care, which can lead to poorer outcomes for people in institutional settings and result in costly emergency department visits and hospitalizations.[130] [131] [132] Accordingly, understaffing can reduce the cost-effectiveness of Medicaid institutional services.

In response to these concerns about the institutional workforce, we are proposing new Federal requirements that are intended to promote public transparency around States' statutory obligation under section 1902(a)(30)(A) of the Act and around the quality requirements in section 1932(c) of the Act for services furnished through managed care organizations (as well as for prepaid inpatient health plans (PIHPs) under our authority under section 1902(a)(4) of the Act), to make Medicaid payments that are sufficient to enlist enough providers so that quality LTSS are available to the beneficiaries who want and require such care. Specifically, we are proposing to add new Federal requirements that are intended to promote better understanding and transparency related to the percentages of Medicaid payments for nursing facility and ICF/IID services that are spent on compensation to direct care workers and support staff. We note that this proposal is specific to nursing facility and ICF/IID services, which we at times may refer to collectively in this preamble as ''institutional services.'' We also note that unlike in sections I. and II. of this proposed rule, we will not be referring to LTC facilities, as the term ''LTC facility,'' for our purposes in this section, is both over-inclusive (because it can refer to both Medicare- and Medicaid-certified nursing facilities) and under-inclusive (because the term typically is not used to describe ICF/IIDs.)

We are focusing in this proposal on compensation because many direct care workers and support staff earn low wages and receive limited benefits.[133] Evidence suggests that there is a connection between wages and high rates of turnover among some workers in the institutional workforce.[134] However, we recognize that other factors, such as local labor market conditions, worker satisfaction, facility culture, and management practices, also play important roles in worker turnover and shortages.[135] Many of these other factors lie outside of our regulatory purview or the scope of this proposal. This proposal is centered on our authority under sections 1902(a)(4), 1902(a)(30), and 1932(c) of the Act to examine specific ways in which Medicaid payments in fee-for-service (FFS) and managed care delivery systems are allocated to support efficient, effective, and high-quality LTSS.

We are aware that some interested parties, including commenters who responded to the FY2023 SNF PPS RFI, have expressed concerns about whether some States' Medicaid rates have kept pace with rising labor costs.[136] We are

United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[127] Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019.* Chicago, IL: Mathematica, December 9, 2021. Accessed at *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.*

[128] Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[129] Centers for Medicare & Medicaid Services. November 2020. Long-Term Services and Supports Rebalancing Toolkit. Accessed at *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.*

[130] Ochieng, N., Chidambaram, P., Musumeci, M. Nursing Facility Staffing Shortages During the COVID–19 Pandemic. Apr 04, 2022. Kaiser Family Foundation. Accessed at *https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/.*

[131] Harrington, C., Carrillo, H., Garfield, R., Squires, E. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016. Apr 03, 2018. Kaiser Family Foundation. Accessed at *https://www.kff.org/report-section/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016-staffing-levels/.*

[132] Min A., Hong HC. Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A Cross-sectional study using the US Nursing Home Compare database. Geriatr Nurs. 2019 Mar–Apr;40(2):160–165. doi: 10.1016/j.gerinurse.2018.09.010. Epub 2018 Oct 4. PMID: 30292528.

[133] Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[134] Sharma, H. and Liu, X. Association between wages and nursing staff turnover in Iowa. Innov Aging. 2022; 6(4): igac004. Published online 2022 Feb 5. doi: *https://academic.oup.com/crawlprevention/governor?content=%2finnovateage%2farticle%2fdoi%2f10.1093%2fgeroni%2figac004%2f6522981.*

[135] See, for instance, the discussion of potential factors contributing to turnover of direct care nursing staff in: Zheng Q, Williams CS, Shulman ET, White AJ. Association between staff turnover and nursing home quality—evidence from Payroll Based journal data. J Am Geriatr Soc. 2022 Sep;70(9):2508–2516. doi: 10.1111/jgs.17843. Epub 2022 May 7. PMID: 35524769.

[136] Referring to the Request for Information released April 2022, included in Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the

also aware of the growing scrutiny of nursing facilities that have been purchased by companies such as private equity organizations, and evidence suggests that these business models have an impact on the quality of institutional care.[137] We do not intend through this proposal to express an opinion about amounts of States' expenditures on nursing facility and ICF/IID services, nor to comment on corporate organizational structures within the long-term care industry. As will be discussed in greater detail below, we are focusing in this proposal on data collection and transparency around the issue of compensation to direct care workers and support staff for some types of Medicaid-covered institutional services, not on proposing minimum reimbursement or payment standards for State Medicaid agencies or providers.

We also recognize that there are workforce challenges that may impact access to other Medicaid-covered services aside from institutional services. We are focusing in this proposed rule on addressing the workforce in certain institutional services. We are proposing to address HCBS workforce challenges outside of this rulemaking in the Ensuring Access to Medicaid Services proposed rule (88 FR 27960), published in the May 3, 2023 issue of the **Federal Register**. We will continue to assess the feasibility and potential impact of other possible actions to address workforce shortages in other parts of the health care sector.

B. Purpose and Statutory Basis

Title XIX of the Act established the Medicaid program as a joint Federal and State program to provide medical assistance to eligible individuals. Under the Medicaid program, each State that chooses to participate in the program and receive Federal financial participation (FFP) for program expenditures establishes eligibility standards, benefits packages, and payment rates, and undertakes program administration in accordance with Federal statutory and regulatory requirements. The provisions of each State's Medicaid program are described in the Medicaid ''State plan'' and, as applicable, in documents related to a State's use of other authorities, such as demonstration projects and waivers of State plan requirements. Among other responsibilities, we approve State plans, State plan amendments, demonstration projects authorized under section 1115 of the Act, and waivers authorized under section 1915 of the Act; monitor activities; and review expenditures for compliance with Federal Medicaid law, including the requirements of section 1902(a)(30)(A) of the Act relating to efficiency, economy, quality of care, and access, to ensure that all applicable Federal requirements are met.

Section 1902(a)(30)(A) of the Act requires State Medicaid programs to ensure that payments to providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to beneficiaries at least to the extent as to the general population in the same geographic area. High-quality institutional services require hands-on services delivered by direct care workers. In institutional settings, direct care workers provide a variety of services, including nursing services, assistance with activities of daily living (such as mobility, personal hygiene, and eating), therapies, and recreation. High-quality institutional services also require support staff who maintain the physical environment of the care facility or provide other services for residents (such as housekeeping, janitorial and environmental services, food preparation, and transportation.) We discuss our proposed definitions of direct care workers and support staff in more detail later in the next section.

Without a sufficient number of people joining or remaining in the direct care and support staff workforce, facilities may be less able to meet the care needs of their residents, whether due to understaffing or the hiring of workers without the appropriate training, expertise, or experience to deliver high-quality services and maintain the physical environment of the care facility. Insufficient numbers of qualified direct care workers and support staff can lead to poorer health outcomes and quality of life for people who need institutional services.[138] [139] [140] [141] [142] Further, these challenges can result in facility closures that in some cases result in residents being relocated to other facilities far from their friends and families, due to a lack of immediately-available alternative LTSS options in their geographical area or due to a lack of sufficient time to seek other options for care.[143] Therefore, as discussed in greater detail in the next section, we propose at § 442.43(b) to require that States report annually on the percent of payments claimed by the State for Medicaid-covered services delivered by nursing facilities and ICF/IIDs that are spent on compensation to direct care workers and support staff. As discussed later in this section, this proposal is intended to promote transparency around compensation for direct care workers and support staff. We believe that gathering and sharing data about the amount of Medicaid dollars that are going to the compensation of workers is a critical step in the larger effort to understand the ways we can enact policies that support the institutional care workforce and thereby help advance access to high quality care for Medicaid beneficiaries.

Section 1902(a)(6) of the Act requires State Medicaid agencies to make such reports, in such form and containing such information, as the Secretary may from time to time require, and to

Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels. A proposed rule by the Centers for Medicare & Medicaid Services on 04/15/2022 *https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.*

[137] Centers for Medicare & Medicaid Services. February 13, 2023. Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership. Accessed at *https://www.cms.gov/newsroom/press-releases/biden-harris-administration-continues-unprecedented-efforts-increase-transparency-nursing-home.*

[138] Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[139] Yaa Akosa Antwi and John R. Bowblis. The Impact of Nurse Turnover on Quality of Care and Mortality in Nursing Homes: Evidence from the Great Recession. Upjohn Institute Working Paper 16–249. January 2016. Accessed at *https://research.upjohn.org/cgi/viewcontent.cgi?article=1267&context=up_workingpapers#:~:text=Turnover%20in%20health%20facilities%20reduces,health%20outcomes%20(Thomas%20et%20al.*

[140] Zheng Q, Williams CS, Shulman ET, White AJ. Association between staff turnover and nursing home quality—evidence from Payroll Based journal data. J Am Geriatr Soc. 2022 Sep;70(9):2508–2516. doi: 10.1111/jgs.17843. Epub 2022 May 7. PMID: 35524769.

[141] Harrington, C., Carrillo, H., Garfield, R., Squires, E. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016. Apr 03, 2018. Kaiser Family Foundation. Accessed at *https://www.kff.org/report-section/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016-staffing-levels/.*

[142] Min A, Hong HC. Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A Cross-sectional study using the US Nursing Home Compare database. Geriatr Nurs. 2019 Mar–Apr;40(2):160–165. doi: 10.1016/j.gerinurse.2018.09.010. Epub 2018 Oct 4. PMID: 30292528.

[143] Holder, J., & Jolley, D. (2012). Forced relocation between nursing homes: Residents' health outcomes and potential moderators. Reviews in Clinical Gerontology, 22(4), 301–319. doi:10.1017/S0959259812000147.

comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. Under our authority at section 1902(a)(6) of the Act, and consistent with section 1902(a)(30)(A) of the Act, we propose to newly require that State Medicaid agencies report, at the facility level, on the portion of payments for nursing facility and ICF/IID services that are spent on compensation for the direct care and support staff workforce.[144] While some States have voluntarily established similar transparency policies or initiatives, we believe a Federal requirement is necessary and would be more effective to generate more meaningful and comparable data and support transparency nationwide.

We find no basis for applying these proposed requirements only when States' LTSS delivery systems are FFS, and thus for the same reasons we are proposing them for FFS delivery systems, we are also proposing to apply them when LTSS systems are covered through managed care. For States that contract with MCOs and PIHPs to cover services delivered by nursing facilities and ICF/IIDs, we propose that States report annually on the percent of payments made to nursing facilities and ICF/IIDs that is spent for compensation to direct care workers and support staff. Section 1932(c) of the Act lays out quality assurance standards with which States must comply when delivering Medicaid services through managed care organizations. Including services delivered by managed care organizations is authorized under section 1932(c), which requires the Secretary to both monitor States and consult with States on strategies to ensure quality of care. Additionally, based on our authority under section 1902(a)(4) of the Act to specify ''methods of administration'' that are ''necessary for proper and efficient'' administration of the State plan, we also propose to include prepaid inpatient health plans (PIHPs) in this proposed rule. Again, we see no basis for excluding services furnished through a PIHP from the proposed requirements; throughout this document, the use of the term ''managed care plan'' means MCOs and PIHPs and is used only when the discussion applies to both arrangements.

This proposal is intended to promote transparency around compensation for direct care workers and support staff. We believe that gathering and sharing data about the amount of Medicaid dollars that are going to the compensation of workers is a critical step in the larger effort to understand the ways we can enact policies that support the institutional care workforce, which plays an essential part in the economy, efficiency, and quality of institutional services. We believe that compensation levels are a factor in the creation of a stable workforce, and that a stable workforce will result in better qualified employees, lower turnover, and safer and higher quality care.[145] [146] If individuals are attracted to the institutional LTSS workforce and incentivized to remain employed in it, the workforce is more likely to be comprised of workers with the training, expertise, and experience to meet the diverse and often complex needs of individuals with disabilities and older adults residing in institutions. A stable and qualified workforce will also enable beneficiaries to access providers of the services they have been assessed to need.

As we discuss below, we are not proposing a minimum percentage of Medicaid payments for nursing facility services and ICF/IID services that must be spent on compensation to direct care workers and support staff. We do not have adequate information at this time to determine such a minimum percentage, nor what impact requiring a minimum percentage would have on Medicaid institutional payments. We are aware that data collected from nursing facilities as part of the PBJ reporting program in § 483.70(q) provides the potential to begin extrapolating information about the relationships between staffing hours and staff compensation in nursing facilities that serve Medicaid residents.[147] We also understand that the variability among States' Medicaid institutional payment rate methodologies and payment rates presents challenges to national studies on issues related to staffing and compensation. In addition, we note that, because there are comparatively fewer reporting requirements for ICF/IIDs than there are for nursing facilities, there is a need for greater data and transparency on the workforce in these facilities. We view this proposed transparency requirement as a necessary step in gathering and making publicly available more information about Medicaid institutional payments that can aid in further analyses, which in turn can inform future policy development and potential rulemaking. Please refer to the discussion in section IV. (Collection of Information) of this proposed rule where we discuss in greater detail the specifics of the activities and resources we anticipate would be required from States, managed care plans, and providers to implement and comply with these proposed requirements.

We also note that while aspects of this proposal are intended to complement the goals expressed in section II of this preamble, the following proposals presented below would be, if finalized, distinct provisions. To the extent a court may enjoin any part of a final rule, the Department intends that other provisions or parts of provisions should remain in effect. Should they be finalized, we intend that any provision of the proposals described in this section or in another section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, would be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding is one of utter invalidity or unenforceability, in which event we intend that the provision would be severable from the other finalized provisions described in this section and in other sections and would not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances

C. Proposed Provisions

We are proposing to create a new provision, § 442.43, which would specify requirements for States to report on compensation for direct care workers and support staff as a percentage of Medicaid payments for nursing facility and ICF/IID services. At § 442.43(a)(1), we propose to define compensation to include salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations (29 U.S.C. 201 *et seq.,* 29 CFR parts 531 and 778), and benefits (such as health and dental benefits, sick leave, and tuition reimbursement). In

[144] Throughout this discussion, we use the term ''States'' to include all States, Washington, DC, and the territories that include nursing facility services or ICF/IID services in their State plans.

[145] See, for example, the discussion of low wages among direct care workers in Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[146] See, for example, the discussion of the relationship between staff turnover and nursing home quality in Zheng Q, Williams CS, Shulman ET, White AJ. Association between staff turnover and nursing home quality—evidence from Payroll Based journal data. J Am Geriatr Soc. 2022 Sep;70(9):2508–2516. doi: 10.1111/jgs.17843. Epub 2022 May 7. PMID: 35524769.

[147] See, for example, the use of Payroll Based Journal data to analyze staffing hours and compensation in Bowblis, J., Brunt, C., Xu, H., and Grabowski, D. Understanding Nursing Home Spending And Staff Levels In The Context Of Recent Nursing Staff Recommendations. Health Affairs. 2022:42(2) 197–206.

addition, we propose to define compensation to include the employer share of payroll taxes for direct care workers and support staff delivering Medicaid-covered nursing facility and ICF/IID services (which, while not necessarily paid directly to the workers, is paid on their behalf). We considered whether to include training or other costs in our proposed definition of compensation. However, we believe that a definition that more directly addresses the financial benefits to workers would better measure the portion of the payment for services that went to direct care workers and support staff, as it is unclear that the cost of training and other workforce activities is an appropriate way to quantify the benefit of those activities for workers. We are also concerned that requesting providers to quantify and include costs of non-financial benefits in their reporting would prove burdensome and could introduce a lack of uniformity in determining and reporting related costs. We request comment on our proposed definition of compensation, particularly whether the definition of compensation should include other specific financial and non-financial forms of compensation for the workers included in these proposed provisions.

At § 442.43(a)(2), for the purposes of the proposed reporting provision at § 442.43(b), we propose to define direct care workers to include: nurses (registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists) who provide nursing services to Medicaid-eligible individuals receiving nursing facility and ICF/IID services; certified nurse aides who provide such services under the supervision of one of the foregoing nurse provider types; licensed physical therapists, occupational therapists, speech-language pathologists, and respiratory therapists; certified physical therapy assistants, occupational therapy assistants, speech-language therapy assistants, and respiratory therapy assistants or technicians; social workers; personal care aides; medication assistants, aides, and technicians; feeding assistants; activities staff; and other individuals who are paid to provide clinical services, behavioral supports, active treatment (as defined at § 483.440 [148]), or address activities of daily living (such as those described in § 483.24(b), which includes activities related to mobility, personal hygiene, eating, elimination, and communication), for individuals receiving Medicaid-covered nursing facility and ICF/IID services. Our proposed definition of direct care worker is intended to broadly define such workers to ensure that the definition appropriately captures the diversity of roles and titles that direct care workers may have.

We recognize that our proposed definition of direct care worker differs from the definition of direct care staff at § 483.70(q)(1), which was established for the PBJ reporting program at § 483.70(q). The PBJ reporting program requires that LTC facilities report on the staffing hours of specified direct care staff (but does not require reporting on the compensation for direct care staff). In particular, our proposed definition does not include administrators (or staff whose primary function is administrative or supervisory), nor do we propose to include physicians or physician assistants. This difference is intentional as we are more closely aligning our proposed definition of direct care worker with the definition of direct care worker for a similar provision focused on HCBS in the Ensuring Access to Medicaid Services proposed rule (88 FR 27960), published in the May 3, 2023 issue of the **Federal Register**. We believe that closer alignment of the definition in this proposed rule with the definition in the Ensuring Access to Medicaid Services proposed rule would help to provide a more consistent picture of the direct care workforce for individuals receiving Medicaid-covered LTSS across settings. We also believe that this may reduce State reporting burden. Additionally, we believe the definition of direct care workers proposed in this rule represents a subset of the categories of direct care staff that nursing facilities are already familiar with as part of the PBJ reporting requirement.[149] Further, we note that ICF/IIDs are currently not required to participate in the PBJ reporting, and thus, we do not expect them to be affected by the definition of direct care staff at § 483.70(q)(1).

We request feedback on our proposed definition of direct care worker at § 442.43(a)(2). We specifically request whether there are categories of staff we should add to, or remove from, our proposed definition. Additionally, we are particularly interested in ensuring that this provision includes staff who can be instrumental in helping residents achieve the level of health or develop skills needed to transition from nursing facilities back into the community, assess residents for readiness for transition, and support in discharge planning. We request feedback from the public as to whether our proposed definition appropriately includes workers who provide these services, or if we would need to include such staff as a distinct category of staff within this provision. We also request comment on whether we should adopt the definition of direct care staff at § 483.70(q)(1), instead of our proposed definition of direct care worker. If commenters support adopting the definition of § 483.70(q)(1), we request that they also provide information on whether this definition would include the staff who help residents achieve the level of health or develop the skills needed to transition from nursing facilities back into the community, assess residents for readiness for transition, and support in discharge planning, or if these staff would still need to be specified as a separate category.

We also propose in § 442.43(a)(2) to define direct care workers to include individuals employed by or contracted or subcontracted with a Medicaid provider or State or local government agency. This proposal is in recognition of the varied ownership and employment relationships that can exist in Medicaid institutional services. For instance, differences may include: institutions that are privately owned and operated or facilities owned and operated by a local or State government; facilities that are partially or wholly staffed through a third-party staffing organization through a contractual arrangement; or staff who are employed directly or as independent contractors. We solicit comment on whether this component of our proposed definition adequately captures the universe of potential employment or contractual relationships between institutional facilities and relevant direct care workers.

At § 442.43(a)(3), for the purposes of the proposed reporting requirement at § 442.43(b), we propose to define support staff to include individuals who are not direct care workers and who maintain the physical environment of the care facility or support other services (such as cooking or housekeeping) for residents. Similar to our proposed definition of direct care worker, our proposed definition of support staff is intended to broadly define such workers to ensure that the definition appropriately captures the diversity of roles and titles that such workers may have. Specifically, we

[148] Active treatment services, as defined in 42 CFR 483.440, are services required in ICF/IIDs as part of their Medicaid Conditions of Participation.

[149] Centers for Medicare & Medicaid Services, Electronic Staffing Data Submission Payroll Based Journal: Long-Term Care Facility Policy Manual. *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/PBJ-Policy-Manual-Final-V25-11-19-2018.pdf.*

propose to define support staff to include: housekeepers; janitors and environmental services workers; groundskeepers; food service and dietary workers; drivers responsible for transporting residents; and any other individuals who are not direct care workers and who maintain the physical environment of the care facility or support other services for individuals receiving Medicaid-covered nursing facility and ICF/IID services. We request comment on whether there are other specific types of workers, such as security guards, who should be included in the definition. We are also soliciting comment on whether any of the types of workers listed in this proposal should be excluded from the definition of support staff. We also request comment, generally, on our proposal to include support staff in this proposed reporting requirement.

We propose to define support staff to include individuals employed by or contracted or subcontracted with a Medicaid provider or State or local government agency. Similar to our discussion of the proposed definition of direct care worker in § 442.43(a)(2), our intention with this proposal is to recognize the varied employment relationships that can exist in Medicaid institutional services, including the use of third-party employers. (For instance, a facility may contract with a third-party transportation company to provide transportation services to residents.) We solicit comment on whether this component of our proposed definition adequately captures the universe of potential employment or contractual relationships between institutional facilities and relevant support staff.

Based on our authority at sections 1902(a)(6) and (a)(30)(A) of the Act with respect to FFS, and sections 1902(a)(4) and 1932(c) of the Act with respect to managed care plans, we are proposing new reporting requirements at § 442.43(b) to require States to report annually, by delivery system (if applicable) and by facility, on the percent of Medicaid payments for nursing facility and ICF/IID services that is spent on compensation for direct care workers and on compensation for support staff, at the time and in the form and manner specified by CMS. We believe that this information would help identify national trends and would also help States identify facilities that appear to be outliers in terms of the amount of Medicaid payment going to direct care worker and support staff compensation. We believe that contextualizing direct care worker and support staff compensation information in this manner would help States understand whether current payment rates for nursing facility and ICF/IID services are consistent with economy, efficiency, and quality, and sufficient to ensure meaningful beneficiary access.

We are proposing that the reporting to CMS would be for all Medicaid payments made to nursing facility and ICF/IID providers. For FFS payments, this would include base payments and supplemental payments for nursing facility and ICF/IID services. We note that for FFS base and supplemental payments, we are relying on the definition of ''supplemental payments'' provided in section 1903(bb)(2) of the Act, which defines supplemental payments as Medicaid payments to a provider that are in addition to any base payment made to providers under the State plan or under demonstration authority. As discussed in guidance released in 2021, we interpret ''base payment'' (as used in the definition of ''supplemental payment'' in section 1903(bb)(2)(A) of the Act), to refer to a standard payment to the provider on a per-claim basis for services rendered to a Medicaid beneficiary in an FFS environment. The base payment can include: (1) any payment adjustments; (2) any add-ons; and/or (3) any other additional payments received by the provider that can be attributed to services identifiable as having been provided to an individual beneficiary, including those that are made to account for a higher level of care, complexity, or intensity of services provided to an individual beneficiary.[150]

We are proposing that States report on FFS base and supplemental payments made to facilities because we believe this would provide a comprehensive picture of Medicaid FFS payments made for these services. However, we recognize that, given the variability in both base and supplemental payments across (and even within) States, there may be value in understanding the percent of the base payments alone that is going to compensation for direct care workers and support staff. We solicit comment on whether, for FFS payments, we should instead request reporting on only the percent of base payments spent on such compensation, or separate reporting on the percent of base payments and on the percent of aggregated payments (base plus supplemental payments) spent on such compensation.

We also propose at § 442.43(b) that for States that contract with MCOs and/or PIHPs to cover services delivered by nursing facilities and/or ICF/IIDs, that States report on the percent of payments made by the MCO or PIHP to nursing facilities and ICF/IIDs that is spent for compensation to direct care workers and support staff. For these managed care plans, payments would include the managed care plan's contractually negotiated rate, State directed payments defined in § 438.6(a), pass-through payments defined in § 438.6(a) for nursing facilities, and any other payments from the MCO or PIHP to the nursing facility or ICF/IID. We are also proposing to require that States, if they deliver the relevant services through both FFS and managed care, they report separately for each delivery system.

We note that we are proposing that the reporting be performed annually. We solicit comment on this timeframe. We request comment on whether annual reporting is reasonable, or if we should reduce the frequency of reporting to every other year or every 3 years.

We propose at § 442.43(b)(1) to require this reporting for payments, including FFS base and supplemental payments and payments from managed care plans, to nursing facilities and ICF/IIDs for Medicaid-covered services, with the exception of services offered in swing bed hospitals (as described in § 440.40(a)(1)(ii)(B)). We are proposing to exclude swing bed hospitals, as we do not want to pose a burden on rural hospitals that provide LTSS to a comparatively small number of beneficiaries. We welcome comment on this proposal.

At § 442.43(b)(2), we propose that States exclude from the reporting payments for which Medicaid is not the primary payer. If finalized, this would mean that States would exclude Medicaid payments to cover only cost-sharing payments on behalf of residents who are dually eligible for Medicare and Medicaid and whose skilled nursing care services are paid for by Medicare. We are proposing this exclusion for two reasons. The first is that, given that facilities (particularly nursing facilities) receive revenue from sources other than Medicaid, we wish to reiterate that this reporting is limited to only the percent of Medicaid payments going to compensation for direct care workers and support staff (and thus would not include Medicare or private payments). The second reason for this exclusion is that the goal of this reporting, as discussed throughout this preamble, is to collect data demonstrating the

[150] Centers for Medicare & Medicaid Services, State Medicaid Directors Letter # 21–006, New Supplemental Payment Reporting and Medicaid Disproportionate Share Hospital Requirements under the Consolidated Appropriations Act, 2021, December 10, 2021. *https://www.medicaid.gov/federal-policy-guidance/downloads/smd21006.pdf.*

relationship between Medicaid payments for nursing facility and ICF/IID services and the wages paid to direct care workers and support staff. We believe that including cost-sharing payments for services that were primarily paid for by Medicare is outside the scope of this data collection. However, we solicit feedback from the public on whether including cost-sharing payments for services that were primarily paid for by Medicare would provide a more accurate picture of the relationship between Medicaid payments and worker compensation. We also request comment on whether excluding cost-sharing payments would increase or decrease burden on States and providers.

We also note that we are not proposing to exclude beneficiary contributions to their care when Medicaid is the primary payer of the services. For FFS programs, base payments included in the reporting should be representative of the total payment amount a provider would expect to receive as payment-in-full for the provision of Medicaid services to individual beneficiaries. (We note that § 447.15 defines payment-in-full as ''the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual.'') For managed care delivery systems, although the term ''payment-in-full'' as defined at § 447.15 is not applicable, for consistency between FFS and managed care delivery systems, any deductible, coinsurance or copayment required to be paid by the individual would similarly be included in the total amount used to determine the percent of Medicaid payments for nursing facility and ICF/IID services that is spent on compensation for direct care workers and support staff. Therefore, we believe the rate used for comparison should be inclusive of total payment from the Medicaid agency, MCO, or PIHP plus any applicable coinsurance, copayments and deductibles, to the extent that a beneficiary is expected to be liable for those payments. We note that this understanding helps promote consistency with a proposal regarding payment reporting in the Ensuring Access to Medicaid Services proposed rule (see, in particular, the discussion at 88 FR 28012). We welcome feedback on whether commenters believe beneficiary contributions should be excluded.

We considered whether to allow States, at their option, to exclude from their reporting payments to providers that have low Medicaid revenues or serve a small number of Medicaid beneficiaries, based on Medicaid revenues for the service, the number of Medicaid beneficiaries receiving the service, or other Medicaid utilization data including but not limited to Medicaid bed days. We considered this option as a way to reduce State, managed care plan, and provider data collection and reporting burden based on the experience of States that have implemented similar reporting requirements. However, we are concerned that such an option could discourage providers from serving Medicaid beneficiaries or increasing the number of Medicaid beneficiaries served. We request comment on whether we should allow States the option to exclude, from their reporting to us, payments to providers that have low Medicaid revenues or serve a small number of Medicaid beneficiaries, based on Medicaid revenues for the service, the number of Medicaid beneficiaries receiving the service, or other Medicaid utilization data including but not limited to Medicaid bed days. We also request comment on whether we should establish a specific limit on such an exclusion and, if so, the specific limit we should establish, such as to limit the exclusion to providers in the lowest 5th, 10th, 15th, or 20th percentile of providers in terms of Medicaid revenues for the service, number of Medicaid beneficiaries served, or other Medicaid utilization data (including but not limited to Medicaid bed days.)

At § 442.43(c)(1), we propose that the reporting must provide information necessary to identify, at the facility level, the percent of Medicaid payments spent on compensation to: direct care workers at each nursing facility, support staff at each nursing facility, direct care workers at each ICF/IID, and support staff at each ICF/IID. We anticipate that States and providers would be able to obtain the information needed to calculate the percent of Medicaid payments made to direct care workers and support staff using data used in rate setting, internal wage information, cost reports, and resident census numbers (which would indicate the number of days residents had Medicaid-covered stays during the year.) However, we solicit comment on our proposal that information be reported at the facility level, particularly on any concerns about potential burden on providers and States.

In constructing this proposal, we sought to balance the need for useful data with burden on States and providers, and we do not want to request more information than is necessary to get basic insight into the relationship between Medicaid payments and direct worker and support staff compensation. To that end, we are proposing to include in the reporting requirement the percentages of Medicaid payments to each nursing facility or ICF/IID that are going towards compensation to direct care workers and support staff at those facilities. However, we would consider adding to the proposed reporting requirements additional elements for States to report on median hourly compensation for direct care workers and median hourly compensation for support staff, in addition to the percent of Medicaid payments going to overall compensation for these workers. If commenters believe reporting on median compensation would yield useful information, we request that commenters also provide feedback on whether the reporting should be on salary/wages, or on total compensation (salary/wages and other remuneration, including employer expenditures for benefits and payroll taxes), and whether the information should be calculated for all direct care workers and for all support staff, or further broken down by the staff categories specified in our proposal at § 442.43(a)(2) and (3).

At § 442.43(c)(2), we propose that States must report the information required at § 442.43(c)(1) (the percent of Medicaid payment going to compensation for direct care workers and support staff and, if added to the provision, median hourly wages) according to a methodology that we provide. We believe it is important to have States use a consistent methodology when collecting and reporting information from facilities. If this proposal is finalized, we would specify a reporting methodology as part of the reporting instrument, which would be submitted separately for formal public comment under the processes set forth by the Paperwork Reduction Act. We are not proposing to codify a specific reporting methodology to allow for increased flexibility to refine and adapt the reporting methodology as States and CMS gain experience with the process. At this time, we solicit initial suggestions for an appropriate methodology for identifying the percentage of Medicaid payment that has gone to direct care worker and support staff compensation (noting that the underlying elements of the methodology could change should any final reporting requirements change in response to comments received on this proposed rule). We also solicit initial suggestions whether separate methodologies would be appropriate for base payments and supplemental payments, and if so, suggestions for each. Commenters who support adding

a requirement to report median hourly wages are also welcome to provide suggestions for a methodology for those calculations.

To support our goal of transparency, we are considering adding a provision requiring that States make publicly available information about the underlying FFS payment rates themselves for nursing facility and ICF/IID services. We believe it is likely that being able to view the reported information (percent of Medicaid payments going to compensation for direct care workers and support staff and, if added to the provisions, the median hourly wages) might be more meaningful if interested parties could review this data with the added context of information about typical nursing facility and ICF/IID FFS per diem payments in those States that use a FFS delivery model for these services. While we approve States' FFS methodologies for setting the rates for nursing facility and ICF/IID services as part of the State plan amendment process, we do not currently require States to report the rates for these services. Further, the amounts can change over time without further State plan review according to the CMS-approved rate methodology (for example, when the State plan rate methodology is based on Medicare rates for services and not a fixed fee schedule). We have also heard from interested parties that members of the public would be interested in comparing the per diem rates nationally. Additionally, we have heard from providers that, as Medicaid payments to individual facilities may vary due to differences in acuity, add-on payments, or other factors, providers would be interested in comparing their own Medicaid revenues against an average or typical per diem rate in their State. We are considering adding to the proposed reporting provisions a requirement that, as applicable, States report a single average statewide FFS per diem rate (one reported rate for nursing facility services and one reported rate for ICF/IID services.) If commenters agree that this information should be added to the reporting requirements, we request comment on whether the reported average should be the average of only the per diem base payment rates, or the average of the per diem base payment rates plus supplemental payments. We are weighing both options, as reporting on the average of the per diem base payment rate (without including supplemental payments) would provide an average that is more representative of the ''typical'' per diem rate (since not all facilities necessarily receive supplemental payments.) On the other hand, an average that includes both the per diem base payment rate and supplemental payments would provide a more complete picture of the total Medicaid spending on these services. We request comment on which option interested parties believe would provide the most useful snapshot of payment for these services.

We do note that in the Ensuring Access to Medicaid Services proposed rule (88 FR 27960), we are proposing at § 447.203(b)(1) that States publish all Medicaid FFS rates. This new proposed process would require States to publish their FFS Medicaid base payment rates in a clearly accessible, public location on the State's website. In § 447.203(b)(2) and (3) of the Ensuring Access to Medicaid Services proposed rule, we proposed that States would be required to conduct a comparative payment rate analysis between the States' Medicaid payment rates and Medicare rates for certain services, and provide a payment rate disclosure for certain HCBS that would include an average hourly rate for those specified HCBS.

We believe that the proposal we are considering here is both complementary to, and distinguishable from, the proposals in the Ensuring Access to Medicaid Services proposed rule. The payment rate transparency proposal in the Ensuring Access to Medicaid Services proposed rule at § 447.203(b)(1), while comprehensive, would request specifically payment rates made to providers delivering Medicaid services to Medicaid beneficiaries through the FFS delivery model. To the extent rates are bundled, we are proposing publication of unbundled rates by constituent service. This is distinct from the proposal in this proposed rule, which is proposing to examine per diem rates, solely in nursing facilities and ICF/IID. A per diem rate is akin to a bundled rate and typically is not reflective of the cost of an individual service; as such, the proposals generally would examine different payment rates. Additionally, the comparative payment rate analysis proposed in the Ensuring Access to Medicaid Services proposed rule at § 447.203(b)(2) focuses on comparing to Medicare rates for specified services, which is not an element included in this proposal. Finally, the proposal in the Ensuring Access to Medicaid Services proposed rule at § 447.203(b)(3) that would require disclosure of hourly payment rates is for HCBS and would therefore not overlap with nursing facility and ICF/IID services.

We also note that this potential reporting requirement would only be for FFS systems. For managed care programs, we are not considering requiring the public reporting of the contractually negotiated rates for individual providers. .

We considered whether to propose a requirement that a minimum percentage of all Medicaid payments, including but not limited to base payments and supplemental payments, with respect to Medicaid-covered nursing facility services and ICF/IID services be spent on compensation to direct care workers and support staff. However, we do not have adequate information at this time to determine a minimum percentage of the payments for Medicaid-covered nursing facility services and ICF/IID services that should be spent on compensation for direct care workers and support staff. In consideration of potential future rulemaking, we request comment on whether we should require that a minimum percentage of the payments for Medicaid-covered nursing facility services and ICF/IID services be spent on compensation for direct care workers and support staff. We also request comment on whether such a requirement would be necessary to ensure that payment rates and methodologies are economic and efficient and consistent with meaningful beneficiary access to safe, high-quality care, or otherwise necessary for the proper and efficient operation of the State plan. Additionally, we request suggestions on the specific minimum percentage of payments for Medicaid-covered nursing facility services and ICF/IID services that should be required to be spent on compensation to direct care workers and support staff. If a minimum percentage is recommended, we request that commenters provide separate recommendations for nursing facility services and ICF/IID services and the rationale for each such minimum percentage that is recommended. We request that commenters provide data or evidence to support such recommendations, which we will review as part of our consideration of policy and rulemaking options.

Based on our authority in sections 1902(a)(6) and 1902(a)(30)(A) of the Act with respect to FFS, and sections 1902(a)(4) and 1932(c) of the Act with respect to managed care plans, we are proposing new requirements to promote public transparency related to the administration of Medicaid-covered institutional services. We believe that promoting public transparency is an important first step for holding States accountable for ensuring that Medicaid payments are used in a way that is efficient and economic, to provide a

foundation for future analyses of whether the payments are sufficient to enlist enough providers so that quality LTSS are available to the beneficiaries who want and require such care. Feedback from interested parties during various public engagement activities over the past several years has indicated that States do not routinely make publicly available information on the percent of payments that are going to the workforce, specifically. As a result, we believe that the proposal described immediately below is needed to support the efficient administration of Medicaid coverage of nursing facility and ICF/IID services by promoting public transparency and accountability related to the percent of payments for such services that goes to compensation to direct care workers and support staff.

Specifically, at § 442.43(d), we propose to require States to operate a website that meets the availability and accessibility requirements at § 435.905(b) of this chapter and that provides the results of the newly proposed reporting requirements in § 442.43(b). We request comment on whether the proposed requirements at § 435.905(b) are adequate to ensure the availability and the accessibility of the information for people receiving LTSS and other interested parties. We note that the accessibility and availability requirements set forth in § 435.905(b) focus on whether the language used on a website is accessible to computer users with disabilities or limited English proficiency. Other accessibility considerations, including the labelling of website links, ensuring the website content is up-to-date, or providing specific information about how users may access assistance are addressed in subsequent proposals below.

At § 442.43(d)(1), we propose to require that the data and information that States are required to report in § 442.43(b) be provided on one website, either directly or by linking to relevant information on the websites of the managed care plan that is contracted to cover nursing facility or IFC/IID services. We intend for the States to be ultimately responsible for ensuring compliance with the proposal, including to ensure through contractual arrangements with managed care plans, as applicable, that the proposed requirements are satisfied when required information is provided on websites maintained by these plans. Proposed § 442.43(d) contemplates that some States that provide nursing facility or ICF/IID services through managed care may decide to work with their managed care plans to make the reporting information available on the managed care plans' websites, rather than replicating the information directly on the State's website. We request comment on whether States should be permitted to link to websites of these managed care plans, and if so, whether we should limit the number of separate websites that a State could link to in place of directly reporting the information on its own website; or whether we should require that all the required information be posted directly on a website maintained by the State.

At § 442.43(d)(2), we propose to require that the website include clear and easy to understand labels on documents and links. At § 442.43(d)(3), we propose to require that States verify the accurate function of the website and the timeliness of the information and links at least quarterly. We note here that the intent of § 442.43(d)(3) is to require that States ensure that the reporting information on their own website is up to date. We would also expect, if the State is linking to a managed care plan website, that the State ensure on at least a quarterly basis that the links are operational and continue to link to the information States are required to report in § 442.43(b). We are not proposing to direct that managed care plans must also review their websites quarterly, but rather we expect that States would develop a process with their managed care plans to ensure that any reporting information contained on a managed care plan website is timely and accurate. If a State obtains information that a managed care plan website to which the State links as a means of publishing the required reporting information is not being maintained with timely updates for ongoing accuracy, we expect that the State would work with the relevant managed care plan to correct the situation and, if unsuccessful, would cease linking to that managed care plan's website and would begin to post the required reporting information on a State-maintained website. We request comment on this proposal, including whether this timeframe for website review is sufficient or if we should require a shorter timeframe (monthly) or a longer timeframe (semi-annually or annually).

At § 442.43(d)(4), we propose to require that States include prominent language on the website explaining that assistance in accessing the required information on the website is available at no cost to the public and include information on the availability of oral interpretation in all languages and written translation available in each non-English language, how to request auxiliary aids and services, and a toll-free and TTY/TDY telephone number. We request comment on whether these requirements are sufficient to ensure the accessibility of the information for people receiving nursing facility or ICF/IID services and other interested parties.

We are also proposing at § 442.43(e) that we must report on our website (Medicaid.gov or a successor website) the information reported by States to us under § 442.43(b). Specifically, we envision that we would update our website to provide information reported by each State on the percent of payments for Medicaid-covered services delivered by nursing facilities and ICF/IIDs that is spent on compensation to direct care workers and support staff (and, if added to the provision, information on median hourly wages) which would allow the information to be compared across States and providers. We also envision using data from State reporting in future iterations of the CMS Medicaid and CHIP Scorecard.[151] We note that if, based on public comment, we add a requirement that States provide information about their payment rates for nursing facility and ICF/IID services, we would provide this information on our website as a way of providing easy-to-find context for the other payment information reported by States. We currently do not intend to include the information on payment rates in the CMS Medicaid and CHIP Scorecard.

We recognize that many States may need time to implement these requirements, including to amend provider agreements or managed care contracts, make State regulatory or policy changes, implement process or procedural changes, update information systems for data collection and reporting, or conduct other activities to implement these proposed payment transparency reporting requirements. We also expect that it would take a substantial amount of time for managed care plans and providers to establish the necessary systems, data collection tools, and processes necessary to collect the required information to report to States. As a result, we are proposing, at § 442.43(f), to provide States with 4 years to implement these requirements in FFS delivery systems following the effective date of the final rule. This proposed timeline reflects feedback from States and other interested parties that it could take 3 to 4 years for States to complete any necessary work to amend State regulations, policies, operational processes, information

[151] CMS's Medicaid and CHIP Scorecard. Accessed at *https://www.medicaid.gov/state-overviews/scorecard/index.html.*

systems, and contracts to support implementation of the proposals outlined in this section. We invite comments on whether this timeframe is sufficient, whether we should require a shorter or longer timeframe (such as 3 or 5 years) to implement these provisions, and if a shorter or longer timeframe is recommended, the rationale for that shorter or longer timeframe.

In the context of Medicaid coverage of nursing facility and ICF/IID services, we believe that the foregoing reasons for the reporting requirements proposed in this rule apply to the delivery of these services regardless of whether they are covered directly by the State on an FFS basis or by a managed care plan for its enrollees. Accordingly, we are proposing to apply the requirements at § 442.43 to both FFS and managed care delivery systems through incorporation by reference in a new regulation in 42 CFR part 438, which generally governs Medicaid managed care programs. Specifically, we propose to add a cross-reference to the requirements in proposed § 438.72(a) to be explicit that States that include nursing facility and/or ICF/IID services in their MCO or PIHP contracts would have to amend their contracts to the extent necessary to comply with the requirements at § 442.43 and propose at § 442.43(b) that payments from MCOs and PIHPs count as ''Medicaid payments'' for purposes of those requirements. We believe this would make the obligations of States that implement LTSS programs through a managed care delivery system clear and consistent with the State obligations for Medicaid FFS delivery systems. Additionally, for States with managed care delivery systems under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and that include coverage of nursing facility services and/or ICF/IID services in the MCO's or PIHP's contract, we are proposing to provide States until the first managed care plan contract rating period that begins on or after the date that is 4 years after the effective date of the final rule to implement these requirements. We solicit feedback on the proposed application of the reporting requirement to managed care and the proposed effective date. We also invite comments on whether the proposed effective date timeframe is sufficient, whether we should require a longer timeframe (such as 5 years) to implement these provisions, and if a longer timeframe is recommended, the rationale for that longer timeframe.

We expect that, should we finalize these reporting requirements, we would establish new processes and forms for States to meet the reporting requirements, provide additional technical information on how States can meet the reporting requirements, and establish new templates consistent with requirements under the Paperwork Reduction Act. We invite comment on this approach, particularly regarding any additional guidance we would need to provide or actions we would need to take to facilitate States' implementation of these proposed provisions.

Finally, in consideration of potential future rulemaking, we request comment on whether we should propose that States implement an interested parties' advisory group in parallel with proposed requirements at § 447.203(b)(6) in the Ensuring Access to Medicaid Services proposed rule (88 FR 29260). Per the discussion in the Ensuring Access to Medicaid Services proposed rule at 88 FR 28024, we are proposing at § 447.203(a)(6) to require States to establish an interested parties advisory group to advise and consult on the sufficiency of FFS rates paid to direct care workers providing certain HCBS. We would be interested in hearing from the public if we should consider developing requirements for States to establish a similar group to advise and consult on nursing facility and ICF/IID service rates.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comments before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In analyzing information collection requirements (ICRs), we rely heavily on wage and salary information. Unless otherwise indicated, we obtained all salary information from the May 2022 National Occupational Employment and Wage Estimates, BLS at *https://www.bls.gov/oes/current/oes_nat.htm.* We have calculated the estimated hourly rates in this proposed rule based upon the national mean salary for that particular position increased by 100 percent to account for overhead costs and fringe benefits. The wage and salary data from the BLS do not include health, retirement, and other fringe benefits, or the rent, utilities, information technology, administrative, and other types of overhead costs supporting each employee. The HHS wide guidance on preparation of regulatory and paperwork burden estimates states that doubling salary costs is a good approximation for including these overhead and fringe benefit costs.

Table 6 presents the BLS occupation code and title, the associated LTC facility staff position in this regulation, the estimated average or mean hourly wage, and the adjusted hourly wage (with a 100 percent markup of the salary to include fringe benefits and overhead costs). Where available, the mean hourly wage for Nursing Care Facilities (Skilled Nursing Facilities) [152] was used.

[152] *https://www.bls.gov/oes/current/naics4_623100.htm.*

TABLE 6—SUMMARY INFORMATION OF ESTIMATED HOURLY COSTS

Occupation code	BLS occupation title	Associated position title in this regulation	Mean hourly wage ($/hour)	Adjusted hourly wage (with 100% markup for fringe benefits & overhead) ($/hour) (rounded to nearest dollar)
29–1141	Registered Nurses (Nursing Care Facilities (Skilled Nursing Facilities)).	Registered Nurse	$37.11	$74
11–9111	Medical and Health Services Managers (Nursing Care Facilities (Skilled Nursing Facilities)).	Director of Nursing (DON) and Administrator.	49.91	100
29–1216	General Internal Medicine Physicians (General Medical and Surgical Hospitals).	Medical Director	93.90	188
43–6013	Medical Secretaries and Administrative Assistants (General Medical and Surgical Hospitals).	Administrative Assistant	20.30	41
29–1229	Physician, All Other (Specialty (except Psychiatric and Substance Abuse)).	Medical Director	135.86	272
29–1031	Dieticians and Nutritionists (Nursing Care Facilities (Skilled Nursing Facilities))	Food and Nutrition Manager	31.63	63
11–3013	Facilities Manager	Facilities Manager	50.95	102
29–2061	Licensed Practical and Licensed Vocational Nurses (Nursing Care Facilities (Skilled Nursing Facilities)).	Licensed Nurse	28.10	56
31–1131	Nursing Assistants (Nursing Care Facilities (Skilled Nursing Facilities)).	Certified Nursing Assistance (CNA).	16.90	34

We are soliciting public comments on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding § 483.35 Nursing Services

At § 483.35(a), we propose that each LTC facility would have to provide services by sufficient numbers of each of the following types of personnel identified in this section on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. Except when exempted under paragraph (g) of this section, licensed nurses, including but not limited to 0.55 hours per resident day of registered nurses; and other nursing personnel, including but not limited to 2.45 hours per resident day of NAs or, if necessary, LPNs. Except when waived under paragraph (e) of this section, each LTC facility must also have a RN on site 24 hours per day, for 7 days a week that is available to provide direct resident care.

These proposed requirements would require each LTC facility to review and modify, as necessary, its policies and procedures regarding nurse staffing. We believe the review and modifications to the necessary policies and procedures would require activities by the director of nursing (DON), an administrator, and an administrative assistant. The DON and the administrator would need to review the requirements, as well as the facility assessment, to determine if any changes are were necessary to the policies and procedures and, if so, make those necessary changes. The DON would then need to work with a medical administrative assistant to ensure that those changes were made to the appropriate documents and ensure that all appropriate individuals in the facility were made aware of the changes. We estimate that these activities would require 2 burden hours for an administrator at a cost of $200 ($100 × 2), 3 hours for the DON at a cost of $300 ($100 × 3), and 1 hour for the administrative assistant at a cost of $41 ($41 × 1). Hence, for each LTC facility the burden estimate would be 6 hours (2 + 3+1) at a cost of $ 541 ($200 + $300 + $41). There are currently 14,688 LTC facilities. Thus, the burden for all LTC facilities would be 88,128 (14,688 × 6) hours at a cost of $7,946,208 ($541 × 14,688 LTC facilities).

B. ICRs Regarding § 483.71 Facility Assessment

For the proposed new section, § 483.71 Facility assessment, we propose to relocate the existing requirements at § 483.70(e) Facility assessment to the new § 483.71. We also propose to modify certain specific requirements and add a third section that will set forth the activities for which we expect LTC facilities to use their facility assessments.

We are proposing to relocate current § 483.70(e)(1) (i) through (v) to § 483.71(a)(1)(i) through (v). This section sets forth what the facility assessment must address or include, but is not limited to, regarding the facility's resident population. At § 483.71(a)(1)(ii), we propose to add ''using evidence-based, data-driven methods'' and ''behavioral health issues'' so that the requirement would now read, ''(ii) The care required by the resident population, using evidence-based, data driven methods that consider the types of diseases, conditions, physical and behavioral health issues, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;''. At § 483.71(a)(1)(iii), we propose to add, ''and skill sets'' so the requirement reads, (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. We believe these modifications constitute clarifications in the requirements and are not new requirements for which the LTC facilities must comply. Hence, we will not be analyzing any new or additional burden related to these changes.

We propose to relocate the current requirements at § 483.70(e)(2)(i) through (vi) to § 483.71(a)(2)(i) through (vi). At § 483.71(a)(2)(iii), we propose to add ''behavioral health'' so that the requirement reads, (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies. Behavioral health services requirements are set forth at § 483.40 and are integral to the health of residents. All LTC facilities should be considering the behavioral health care needs of their residents. Hence, this change does not constitute a new requirement but a clarification. Hence, we will not be

analyzing any new or additional burden related to this change.

We propose to add a new requirement at § 483.71(a)(4) for LTC facilities to incorporate the input of facility staff and their representatives into their facility assessment. These staff categories include, but are not limited to, nursing home leadership, management, direct care staff and representatives and other service workers. We believe that LTC facilities already include many of these categories of individuals when they conduct or update their facility assessments. Thus, this requirement constitutes a clarification and not a new requirement. Hence, we will not be analyzing any new or additional burden related to this change.

We propose to add new requirements at § 483.71(b). These requirements set forth specific activities for which the LTC facilities would be expected to use their facility assessments. These assessments would inform staffing decisions to ensure that a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3); consider specific staffing needs for each resident unit in the facility, and adjust as necessary based on changes its to resident population; consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population; and, develop and maintain a plan to maximize recruitment and retention of direct care staff.

We believe that LTC facilities are either already using their facility assessments for these activities or will be based upon the other requirements in this proposed rule, except for using their facility assessments to develop and maintain a plan to maximize recruitment and retention of direct care staff. Based upon our experience with LTC facilities, these facilities are already working on recruitment and retention of direct care staff. However, we also believe these facilities would need to review their current efforts to determine if there are opportunities to improve their efforts and, if so, decide how to do so. The LTC facility's facility assessment would require the development of a plan to maximize recruitment and retention and accomplish the associated tasks and would also be an invaluable tool in assessing and maintaining sufficient staff for their facility.

The staff involved in developing this plan would vary by the type of care and services provided by the individual facilities. Some LTC facilities might have various therapists on staff, such as physical and occupational therapists. Others might employ psychologists, social workers, or complementary medicine or American Indian/Alaska Native Traditional Healers who provide behavioral health services to residents. When developing a recruitment and retention plan, we encourage LTC facilities to include participation, or at least input, from the various types of direct care staff in their facilities and representatives of these workers, although the hours worked by those staff cannot be used as substitutes for the direct care minimums for RNs and NAs required under this rule. All LTC facilities provide 24-hour nursing services and the direct care nursing staff would include RNs, other licensed nurses (LPNs or LVNs), and nursing assistants (NAs). For the purpose of estimating the burden for developing a recruitment and retention plan, we estimate the burden for an administrator, the DON, and one individual from each of the nursing categories, an RN, LPN/LVN, and NA to develop the plan. These individuals would have to meet to develop a plan and then the administrator will need to obtain approval for the plan from the governing body. During the development process and after approval, an administrative assistant would need to provide support and ensure the plan is disseminated and save appropriately in the facility's records. We estimate that developing a recruitment and retention plan would require 6 hours for an administrator at a cost of $600 ($100 × 6); 6 hours for the DON at a cost of $600 ($100 × 6); 4 hours for a registered nurse at a cost of $296 ($74 × 4); 2 hours for a LPN/LVN at a cost of $112 ($56 × 2); 2 hours for a nursing assistant at a cost of $68 ($34 × 2); and, 2 hours for an administrative assistant $82 ($41 x 2). Thus, the burden for each LTC facility is 22 (6 + 6 + 4 + 2 + 2 + 2) hours at an estimated cost of $1,758 ($ 600 + $600 + $296 + $112 + $68 + 82). For all 14,688 LTC facilities the burden would be 323,136 hours (14,688 LTC facilities x 22) at an estimated cost of $25,821,504 ($1,758 × 14,688 LTC facilities). We are requesting comment on our estimated number of burden hours for the proposal for each of the activities and total annual burden and cost for each facility.

Hence, the total estimated burden for the ICRs in part 483 is 411,264 (88,128 + 323,136) hours at a cost of $33,767,712 ($7,946,208+ $25,821,504). The burden will be included in this revised Information Collection Request under the OMB control number 0938–1363; Expiration date: April 30, 2026.

C. ICR Related to Medicaid Institutional Payment Transparency

1. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics (BLS) May 2022 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, Table 7 presents BLS's mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 7—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Administrative Services Manager	11–3012	55.59	55.59	111.18
Chief Executive	11–1011	118.48	118.48	236.96
Compensation, Benefits, and Job Analyst	13–1141	36.50	36.50	73.00
Computer Programmer	15–1251	49.42	49.42	98.84
General and Operations Manager	11–1021	59.07	59.07	118.14
Management Analyst	13–1111	50.32	50.32	100.64
Training and Development Specialist	13–1151	33.59	33.59	67.18

For States and the private sector, our employee hourly wage estimates have been adjusted by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly across employers, and because methods of estimating these costs vary widely across studies. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

To estimate the financial burden on States related to the proposed Medicaid Institutional Payment Transparency Reporting provisions (discussed below), it was important to consider the Federal government's contribution to the cost of administering the Medicaid program. The Federal government provides funding based on a Federal medical assistance percentage (FMAP) that is established for each State, based on the per capita income in the State as compared to the national average. FMAPs range from a minimum of 50 percent in States with higher per capita incomes to a maximum of 83 percent in States with lower per capita incomes. For Medicaid, all States receive a 50 percent FMAP for administration. States also receive higher Federal matching rates for certain systems improvements, redesign, or operations. Taking into account the Federal contribution to the costs of administering the Medicaid programs for purposes of estimating State burden with respect to collection of information, we elected to use the higher end estimate that the States would contribute 50 percent of the costs, even though the burden would likely be much smaller. We are requesting comment on our estimated number of burden hours for the proposal for each of the activities and total annual burden and cost for each facility.

3. Proposed Information Collection Requirements (ICRs)

The following proposed changes will be submitted to OMB for their approval when our survey instrument has been developed; we are using feedback from this proposed rule to inform the development of the survey instrument. The survey instrument and burden will be made available to the public for their review under the standard non-rule PRA process which includes the publication of 60- and 30-day **Federal Register** notices. In the meantime, we are setting out our preliminary burden figures (see below) as a means of scoring the impact of this rule's proposed changes. The availability of the survey instrument and more definitive burden estimates will be announced in both **Federal Register** notices. The CMS ID number for that collection of information request is CMS–10851 (OMB control number 0938–TBD). Since this would be a new collection of information request, the OMB control number has yet to be determined (TBD) but will be issued by OMB upon their approval of the new collection of information request. Note that we intend that the following proposed changes associated with §§ 442.43(b), (c), and (d), discussed later in this section, will be submitted to OMB for review as a single PRA package under control number 0938–TBD (CMS–10851).

a. State and Provider Burden Under § 442.43(b) and (c)—Payment Transparency Reporting

As discussed in section III. of this proposed rule, under our authority at sections 1902(a)(6) and 1902(a)(30)(A) with respect to FFS, and sections 1902(a)(4) and 1932(c) of the Act with respect to managed care, we are proposing new reporting requirements at § 442.43(b) for States to report annually on the percent of payments for Medicaid-covered services delivered by nursing facilities and ICF/IIDs that are spent on compensation for direct care workers and support staff. (Our proposed definitions of who is included in direct care workers and support staff, at proposed §§ 442.43(a)(2) and (3), respectively, are discussed in the preamble in section III. of this proposed rule.) The intent of this proposed requirement is for States to report separately, by delivery system and at the provider level, on the percent of payments for nursing facility services that are spent on compensation to direct care workers, the percent of payments for nursing facility services that are spent on compensation to support staff, the percent of payments for ICF/IID services that are spent on compensation to direct care workers, and the percent of payments for ICF/IID services that are spent on compensation to support staff. We propose to add a cross-reference to the requirements in proposed § 438.72 to specify that States that include nursing facility and ICF/IID services in their contracts with managed care organizations (MCOs) or prepaid inpatient health plans (PIHPs) would have to comply with the requirements at § 442.43(b). Where they appear, references to the proposed requirements at § 442.43(b) apply to both FFS and managed care delivery systems.

We are considering adding to the proposed reporting requirements additional elements for States to report on median hourly compensation for direct care workers and median hourly compensation for support staff, in addition to the percent of Medicaid payments going to overall compensation for these workers. Although we may not finalize these additional reporting requirements, we will include them in our cost estimate to avoid underestimating the costs of this proposal. If finalized, we expect that these additional reporting requirements would also apply to both FFS and managed care delivery systems.

We are also considering adding at § 442.43(c) a provision requiring that States make publicly available information about the underlying FFS payment rates themselves for nursing facility and ICF/IID services. If the proposal was finalized, we would require that States report a single average statewide FFS per diem rate (one reported rate for nursing facility services and one reported rate for ICF/IID services) as part of the reporting requirement required at § 442.43(b). Again, to avoid underestimating, we are including the estimated cost of this potential additional requirement in our cost estimates.

(1) State Institutional Payment Transparency Reporting Requirements and Burden

The burden associated with the proposed reporting requirements would affect all 51 States (including Washington DC). While not all States cover ICF/IID services (because it is an optional Medicaid benefit), all States must offer Medicaid nursing facility services (because it is a mandatory Medicaid benefit). Thus, we anticipate that all 51 States (including Washington, DC) would participate in the reporting requirements proposed at § 442.43(b). Additionally, three territories (Guam, Puerto Rico, and the U.S. Virgin Islands) are required to include nursing facility services in their State plans, and thus will be included in these calculations as well.[153] While we will include these territories in our cost estimates, we will continue to refer to the affected entities collectively as ''States''. We estimate both a one-time and ongoing burden to States to implement these requirements at the State level.

[153] Note that due to waiver under section 1902(j) of the Social Security Act, American Samoa and the Commonwealth of the Northern Marianas Islands are not required to include nursing facility services in their State plans and thus are not included in these estimates. Additionally, no territory currently includes the optional ICF/IID benefit in their State plan.

One-Time Reporting Requirements and Burden (§ 442.43(b)): States

Under proposed § 442.43(b) and (c), we anticipate as one-time burdens that States, through their designated State Medicaid agency, would have to: (1) draft new policy describing the State-specific reporting process (one-time); (2) update any related provider manuals and other policy guidance (one-time); (3) build, design, and operationalize an electronic system for data collection and aggregation (one-time); (4) identify the information that would be needed to report the State's per diem rates, if that additional proposal is finalized (one-time); and (5) develop and conduct an initial training for providers on the reporting requirement and State-developed reporting system (one-time). We note that we are not proposing to require that States update their Medicaid State plans as part of this reporting requirement, and thus we are not estimating a burden associated with State plan amendments.

With regard to this one-time burden for States, we estimate it would take: 40 hours at $111.18/hr. for an administrative services manager to draft new policy describing the State-specific reporting process; 14 hours at $100.64/hr. for a management analyst to update any related provider manuals and other policy guidance; an additional 1 hour at $100.64/hr. for a management analyst to identify what information will be needed to report a FFS per diem rate for nursing facility and ICF/IID services,[154] if the additional reporting requirement is finalized; 25 hours at $98.84/hr. for a computer programmer to build, design, and operationalize an electronic system for data collection on the percent of Medicaid payments going to compensation and (if finalized) median hourly compensation, including data aggregation and stratification by provider, provider type, and worker type (direct care worker or support staff); 30 hours at $67.18/hr. for a training and development specialist to develop and conduct training for providers on the reporting requirement and system; 3 hours at $118.14/hr. for a general and operations manager to review and approve policy updates, provider agreement updates, and training materials; and 1 hour at $236.96/hr. for a chief executive to review and approve all operations associated with this requirement.

In addition to these activities outlined above, States may also have to update managed care contracts to reflect the new reporting requirement and provide managed care-specific guidance on the reporting requirement. Recent data indicates that 24 States provide at least some long-term services through managed care.[155] For the managed care-specific burden, we estimate 10 hours at $111.18/hr. for an administrative services manager to draft updates to managed care contracts. (We anticipate that all other State activities associated with managed care plans would be reflected in the activities described previously in this section.)

In aggregate, we estimate a one-time burden of 6,396 hours [(114 hr. × 54 States) + (10 × 24 States)]. We estimate a cost of $595,867 (54 States × [(40 hr. × $111.18) + (15 hr. × $100.64) + (25 hr. × $98.84) + (30 hr. × $67.18) + (3 hr. × $118.14) + (1 hr. × $236.96)]), with an additional $26,683 for managed care-related costs (24 States × [10 hr. × $100.64]). The total cost is estimated at $622,551 ($595,867 + $26,683). Taking into account the Federal contribution to Medicaid administration, the estimated State share of the cost would be $311,275 ($622,551 × 0.50).

TABLE 8—SUMMARY OF ONE-TIME BURDEN FOR STATES FOR THE MEDICAID INSTITUTIONAL PAYMENT TRANSPARENCY REPORTING REQUIREMENTS AT § 442.43(b)

Requirement	Number respondents	Total responses	Frequency	Time per response (hr.)	Total time (hr.)	Wage ($/hr.)	Total cost ($)	State share ($)
Draft new policy describing the State-specific reporting process.	54	54	Once	40	2,160	111.18	240,149	120,074
Update any related provider manuals and other policy guidance.	54	54	Once	14	756	100.64	76,084	38,042
Identify information needed for per diem rate reporting	54	54	Once	1	54	100.64	5,435	2,717
Build, design, and operationalize an electronic system for data collection, aggregate, and stratify reporting.	54	54	Once	25	1,350	98.84	133,434	66,717
Develop and conduct training for providers on the reporting requirement and system.	54	54	Once	30	1,620	67.18	108,832	54,416
Review and approve policy updates and training materials	54	54	Once	3	162	118.14	19,139	9,569
Review and approve all operations associated with this requirement.	54	54	Once	1	54	236.96	12,796	6,398
Draft contract modifications for managed care plans	24	24	Once	10	240	111.18	26,683	13,342
Total	Varies	402	Once	Varies	6,396	Varies	622,551	311,275

Ongoing Reporting Requirements and Burden (§ 442.43(b)): States

Under proposed § 442.43(b), we estimate as ongoing burdens that States would: (1) notify and train nursing facility and ICF/IID providers about the annual reporting requirement, including the State-level process for collecting data (ongoing); (2) collect information from providers annually (ongoing); (3) aggregate or stratify data as needed (ongoing); (4) derive percentages for compensation (ongoing); and (5) develop a report for CMS on an annual basis (ongoing).

With regard to the ongoing burden, we estimate it would take: 8 hours at $67.18/hr. for a training and development specialist to notify and train providers about annual reporting requirement; 2 hours at $100.64 for a management analyst to gather the State's information needed to include per diem

[154] As discussed in section III. of this proposed rule, if finalized, the proposal to report per diem rates for nursing facility and ICF/ID services would only be applied to FFS rates. If finalized, this proposal would not apply to States that deliver nursing facility and ICF/IID services solely through managed care. However, some States with managed care delivery systems still pay for some LTSS under a FFS delivery system. For the purposes of this estimate, we are assuming all States will be participating in this reporting requirement, even though the requirement might apply to fewer than 54 States upon implementation.

[155] Data taken from Centers for Medicare & Medicaid Services, ''Managed Long Term Services and Supports (MLTSS) Enrollees,'' available at *https://data.medicaid.gov/dataset/5394bcab-c748-5e4b-af07-b5bf77ed3aa3.*

rates for the State's FFS nursing facility and ICF/IID services (if finalized); 6 hours at $98.84/hr. for a computer programmer to collect information from providers, aggregate data as needed, derive percentages for compensation, and develop a report for the State; 2 hours at $118.14/hr. by a general and operations manager to review, verify, and submit the report to CMS; and 1 hour at $236.96/hr. for a chief executive to review and approve all operations associated with this requirement.

In aggregate, we estimate an ongoing burden of 1,026 hours (19 hr. × 54 States) at a cost of $97,470 (54 States × [(8 hr. × $67.18) + (2 hr. × $100.64) + (6 hr. × $98.84) + (2 hr. × $118.14) + (1 hr. × $236.96)]. Taking into account the Federal contribution to Medicaid administration, the estimated State share of this cost would be $48,735 ($97,470 × 0.50) per year.

TABLE 9—SUMMARY OF ONGOING BURDEN FOR STATES FOR THE MEDICAID INSTITUTIONAL PAYMENT TRANSPARENCY REPORTING REQUIREMENTS AT § 442.43(b)

Requirement	Number respondents	Total responses	Frequency	Time per response (hr.)	Total time (hr.)	Wage ($/hr.)	Total cost ($)	State share ($)
Notify and train providers about annual reporting requirement	54	54	Annually ..	8	416	67.18	29,022	14,511
Gather information needed to report State FFS per diem rates.	54	54	Annually ..	2	108	100.64	10,869	5,435
Collect information from providers; aggregate data as required; derive an overall percentage for compensation; and develop report for State.	54	54	Annually ..	6	312	98.84	32,024	16,012
Review, verify, and submit report to CMS	54	54	Annually ..	2	104	118.14	12,759	6,380
Review and approve all operations associated with this requirement.	54	54	Annually ..	1	52	236.96	12,796	6,398
Total	54	270	Annually ..	Varies	1,026	Varies	97,470	48,735

(2) Nursing Facility and ICF/IID Institutional Payment Transparency Reporting Requirements and Burden

The burden associated with this proposed rule would affect nursing facility and ICF/IID providers in both FFS and managed care systems. We estimate both a one-time and ongoing burden to implement the reporting requirement proposed at § 442.43(b).

To estimate the number of nursing facility and ICF/IID providers that would be impacted by this proposed rule, we used data from the CMS Quality Certification and Oversight Reports (QCOR) system (*qcor.cms.gov*) to identify the total number of Medicaid-certified nursing facilities and ICF/IIDs in all States (including Washington DC) and the three territories that are required to include nursing facility services in their State plan. Data from QCOR indicates that in FY 2022, there were 14,194 freestanding Medicaid-certified nursing facilities (including facilities dually certified for both Medicare and Medicaid, and Medicaid-only facilities). Additionally, in FY 2022, there were 5,713 ICF/IIDs. In total, we estimate 19,907 Medicaid-certified nursing facilities and ICF/IIDs that could be impacted by this proposed reporting requirement and may need to provide data to the State on what percentage of their Medicaid reimbursements for nursing facility and ICF/IID services went to direct care worker and support staff compensation.

Under proposed § 442.43(b), we anticipate that nursing facilities and ICF/IIDs would need to: (1) learn the State-specific reporting policies and process (one-time); (2) calculate compensation for each direct care worker and support staff if they do not already have that information readily available (one-time); and (3) build, design and operationalize an internal system for developing the report for the State (one-time). We note that we do not anticipate any additional burden on providers associated with the proposed additional reporting requirements (to report median hourly wages and the State's FFS per diem rates). We expect that States would be able to calculate median hourly wages based on the information collected from providers. We also believe the State, not, providers, would have the information needed to report the State's FFS per diem rates for nursing facility and ICF/IID services.

One-Time Reporting Requirements and Burden (§ 442.43(b)): Nursing Facility and ICF/IID Providers

With regard to the one-time burden for providers, we estimate it would take: 10 hours at $73.00/hr. for a compensation, benefits, and job analysis specialist to learn the State-specific reporting policy and calculate compensation for each direct care worker and support staff; 10 hours at $98.84/hr. for a computer programmer to build, design, and operationalize an internal system for developing the report for the State; and 1 hour at $118.14/hr. for a general and operations manager to review and approve the reporting system. In aggregate, we estimate a one-time burden of 418,047 hours (19,907 facilities × 21 hr.) at a cost of $36,560,002 (19,907 providers × [(10 hr. × $73.00) + (10 hr. × $98.84) + (1 hr. × $118.14)].

TABLE 10—SUMMARY OF ONE-TIME BURDEN FOR NURSING FACILITIES AND ICF/IIDS FOR THE MEDICAID INSTITUTIONAL PAYMENT TRANSPARENCY REPORTING REQUIREMENTS AT § 442.43(b)

Requirement	Number respondents	Total responses	Frequency	Time per response (hr.)	Total time (hr.)	Wage ($/hr.)	Total cost ($)	State share ($)
Learn State-specific reporting policy; calculate compensation for each direct care worker and support staff.	19,907	19,907	Once	10	199,070	73.00	14,532,110	n/a
Build, design, and operationalize an internal system for developing the report for the State.	19,907	19,907	Once	10	199,070	98.84	19,676,079	n/a
Review and approve reporting system	19,907	19,907	Once	1	19,907	118.14	2,351,813	n/a
Total	19,907	59,721	Once	Varies	418,047	Varies	36,560,002	n/a

Ongoing Reporting Requirements and Burden (§ 442.43(b)): Nursing Facility and ICF/IID Providers

With regard to the ongoing burden, we anticipate nursing facilities and ICF/IIDs would have to: (1) update compensation calculations to account for on-going staffing changes among direct care workers and support staff (in other words, ensure their system includes newly hired direct care workers or support staff and takes into account staff departures); (2) calculate the aggregated compensation of direct care workers and support staff as a percentage of their annual Medicaid claims (ongoing); and (3) report the information to the State annually (ongoing).

We estimate it would take 8 hours at $73.00/hr. for a compensation, benefits, and job analysis specialist to update compensation calculations to account for staffing changes; 2 hours at $98.84/hr. for a computer programmer to calculate compensation, aggregate data, and report to the State as required; and 1 hour at $118.14/hr. for a general and operations manager to review, approve, and submit the report to the State. In aggregate, we estimate an on-going burden of 218,977 hours (19,907 providers × 11 hr.) at a cost of $17,912,717 (19,907 facilities × [(8 hr. × $73.00) + (2 hr. × $98.84) + (1 hr. × $118.14)].

TABLE 11—SUMMARY OF ONGOING BURDEN FOR NURSING FACILITY AND ICF/IIDS FOR THE MEDICAID INSTITUTIONAL PAYMENT TRANSPARENCY REPORTING REQUIREMENTS AT § 442.43(b)

Requirement	Number respondents	Total responses	Frequency	Time per response (hr.)	Total time (hr.)	Wage ($/hr.)	Total cost ($)	State share ($)
Account for staffing changes among employees and contracted employees.	19,907	19,907	Annually ..	8	159,256	73.00	11,625,688	n/a
Calculate compensation, aggregate data, and report to the State.	19,907	19,907	Annually ..	2	39,814	98.84	3,935,216	n/a
Review, approve, submit report to the State	19,907	19,907	Annually ..	1	19,907	118.14	2,351,813	n/a
Total	19,907	59,721	Annually ..	Varies	218,977	Varies	17,912,717	n/a

b. State Website Posting Requirements and Burden (§ 442.43(d))

At § 442.43(d), we propose to require States to operate a website that meets the availability and accessibility requirements at § 435.905(b) of this chapter and that provides the results of the newly proposed reporting requirements in § 442.43(b). We also propose at § 442.43(d) that States must verify, no less than quarterly, the accurate function of the website and the timeliness of the information and links.

As noted above, we anticipate that this provision would affect all 51 States (including Washington, DC) and the territories required to have nursing facility services in their State plans which we refer to collectively as ''States.''. We estimate both a one-time and ongoing burden to implement these requirements at the State level, which would be the same regardless of whether the State offers nursing facility and ICF/IID services through FFS or managed care systems. In developing our burden estimate, we assumed that States would provide the data and information that States are required to report under newly proposed § 442.43(d) by adding to an existing website, rather than developing an entirely new website to meet this requirement. We note that we are not proposing to require that States update their Medicaid State plans as part of this reporting requirement and are not estimating a burden associated with State plan amendments. We are also not anticipating an additional website burden associated with the possible additional reporting requirements (to report median hourly wage and to report the State's FFS per diem rates) discussed previously in this section as this information, if finalized, would be integrated into the other website posting activities.

One Time Website Posting Requirements and Burden (§ 442.43(d)): States

With regard to the one-time burden, based on the website requirements, we estimate it would take: 10 hours at $111.18/hr. for an administrative services manager to determine the content of the website; 30 hours at $98.84/hr. for a computer programmer to develop the website; 1 hour at $118.14/hr. for a general and operations manager to review and approve the website; and 1 hour at $236.96/hr. for a chief executive to review and approve the website. In aggregate, we estimate a one-time burden of 2,268 hours (54 States × 42 hr.) at a cost of $239,333 (54 States × [(10 hr. × $111.18) + (30 hr. × $98.84) + (1 hr. × $118.14) + (1 hr. × $236.96)]. Taking into account the Federal contribution to Medicaid administration, the estimated State share of this cost would be $119,667 ($239,333 × 0.50) per year.

TABLE 12—SUMMARY OF THE ONE-TIME BURDEN FOR STATES FOR THE WEBSITE POSTING REQUIREMENTS AT § 442.43(f)

Requirement	Number respondents	Total responses	Frequency	Time per response (hr.)	Total time (hr.)	Wage ($/hr.)	Total cost ($)	State share ($)/year
Determine content of website	54	54	Once	10	540	111.18	60,037	30,019
Develop website	54	54	Once	30	1,620	98.84	160,121	80,060
Review and approve the website at the management level ...	54	54	Once	1	54	118.14	6,380	3,190
Review and approve the website at the executive level	54	54	Once	1	54	236.96	12,796	6,398
Total	54	216	Once	Varies	2,268	Varies	239,333	119,667

Ongoing Website Posting Requirements and Burden (§ 442.43(d)): States

With regard to the States' ongoing burden related to the website requirement, per quarter we estimate it would take: 2 hours at $111.18/hr. for an administrative services manager to provide any updated data and information for posting and to verify the accuracy of the website; 8 hours at $98.84/hr. for a computer programmer to make any needed updates to the website; 1 hour at $118.14/hr. for a general and operations manager to review and approve the website; and 1 hour at $236.96/hr. for a chief executive to review and approve the website. In aggregate, we estimate an ongoing annual burden of 2,592 hours (12 hr. × 54 States × 4 quarters) at a cost of $295,527(54 States × 4 quarters × [(2 hr. × $111.18) + (8 hr. × $98.84) + (1 hr. × $118.14) + (1 hr. × $236.96)]. Taking into account the Federal contribution to Medicaid administration, the estimated State share of this cost would be $147,763 ($295,527 × 0.50) per year.

TABLE 13—SUMMARY OF THE ONGOING BURDEN FOR STATES FOR THE WEBSITE POSTING REQUIREMENTS AT § 442.43(f)

Requirement	Number respondents	Total responses	Frequency	Time per response (hr.)	Total time (hr.)	Wage ($/hr.)	Total cost ($)	State share ($)
Provide updated data and information for posting and verify the accuracy of the website.	54	216	Quarterly	2	432	111.18	48,030	24,015
Update website	54	216	Quarterly	8	1,728	98.84	170,796	85,398
Review and approve website at the management level	54	216	Quarterly	1	216	118.14	25,518	12,759
Review and approve website at the executive level	54	216	Quarterly	1	216	236.96	51,183	25,592
Total	54	864	Quarterly	Varies	2,592	Varies	295,527	147,763

4. Burden Estimate Summary

TABLE 14—SUMMARY OF ANNUAL BURDEN ESTIMATES

Regulation section(s)/ICR provision	Number of respondents	Number of responses	Time per response (hrs)	Total time (hr.)	Hourly labor rate ($/hr.)	Total labor cost ($)	State share ($)	Total beneficiary cost ($)
§ 442.43(b) One-Time Burden to States (Table 8) (Payment Transparency Reporting).	Varies	402	Varies	6,396	Varies	622,251	311,275	0
§ 442.43(b) Ongoing Burden to States (Table 9) (Payment Transparency Reporting—Annual).	54	270	Varies	1,026	Varies	97,470	48,735	0
§ 442.43(b) One-Time Burden to Providers (Table 10) (Payment Transparency Reporting).	19,907	59,721	Varies	418,047	Varies	36,560,002	n/a	0
§ 442.43(b) Ongoing Burden to Providers (Table 11) (Payment Transparency Reporting—Annual).	19,907	59,721	Varies	218,977	Varies	17,912,717	n/a	0
§ 442.43(f) One-Time Burden to States (Table 12) (Website Posting).	54	216	Varies	2,268	Varies	239,333	119,667	0
§ 442.43(f) Ongoing Burden to States (Table 13) (Website Posting—Quarterly).	54	864	Varies	2,592	Varies	295,527	147,763	0
Total	Varies	121,194	Varies	649,306	Varies	55,727,300	627,440	0

Comments must be received on/by October 31, 2023.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

1. Minimum Nurse Staffing

With respect to the requirements for minimum nurse staffing in LTC facilities, sections 1819 and 1919 of the Act, authorize the Secretary to issue requirements for participation in Medicare and Medicaid, including such regulations as may be necessary to protect the health and safety of residents (sections 1819(d)(4)(B) and 1919(d)(4)(B) of the Act). Such regulations are codified in the implementing regulations at 42 CFR part 483, subpart B.

Approximately 1.4 million Americans are residents in LTC facilities with Medicare and Medicaid serving as the payor for most residents.[156] As we have discussed in detail in sections II. and III. of this proposed rule, a large body of quantitative and qualitative research suggests that adequate nurse staffing is vital for ensuring residents' health and safety. More specifically, there is a positive association between the number of hours of care that a resident receives each day and resident health and safety.[157] [158] [159] Research also suggests that there is a relationship between inadequate staffing and nursing staff burnout, which can lead to high

[156] *https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/cms-program-statistics-medicare-skilled-nursing-facility.*

[157] Ochieng, N., Chidambaram, P., Musumeci, M. Nursing Facility Staffing Shortages During the COVID–19 Pandemic. Apr 04, 2022. Kaiser Family Foundation. Accessed at *https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/.*

[158] Harrington, C., Carrillo, H., Garfield, R., Squires, E. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016. Apr 03, 2018. Kaiser Family Foundation. Accessed at *https://www.kff.org/report-section/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016-staffing-levels/.*

[159] Min A, Hong HC. Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A Cross-sectional study using the US Nursing Home Compare database. Geriatr Nurs. 2019 Mar-Apr;40(2):160–165. doi: 10.1016/j.gerinurse.2018.09.010. Epub 2018 Oct 4. PMID: 30292528.

employee turnover.[160] High employee turnover, in turn, can lead to lower continuity of resident care.

During our regular interactions with State Medicaid agencies, provider groups, and beneficiary advocates, we have observed that all these interested parties routinely express the concern that chronic understaffing in LTC facilities is making it difficult for residents to receive high quality care. Low quality care also has a negative impact on Medicare and Medicaid leading to higher spending due to more hospitalizations and unplanned Emergency Department visits.[161] [162] [163] As we have noted throughout this rule, the available evidence suggests that a wide range of requirements for LTC facility staff could increase the quality of care in LTC facilities. We also recognized, however, that staffing in the long-term care sector is still recovering from the COVID–19 pandemic that saw a large number of employees leave the sector, leading to concerns about resident access to care. In response to these concerns, and after evaluating a wide range of research and stakeholder feedback, we developed a proposed 24/7 on-site RN requirement and minimum RN and NA HPRD requirements that aim to increase resident safety and quality of care while preserving resident access to care.

Specifically, we are proposing that LTC facilities provide RN coverage onsite 24 hours per day, 7 days a week (24/7 RN). In addition, we are proposing that they provide a minimum of 0.55 RN and 2.45 NA hours of care per resident day (HPRD). We note that, as discussed in section II above, while the 0.55 and 2.45 HPRD standards were developed using case-mix adjusted data sources, the standards themselves will be implemented and enforced independent of a facility's case-mix. In other words, facilities must meet the 0.55 RN and 2.45 NA HPRD standards, regardless of the individual facility's patient case-mix. Requiring 24/7 RN and a minimum number of hours of RN and NA hours of care for each resident will help protect resident health and safety by ensuring that all facilities provide a minimal level of staff care to address residents' health and safety needs. These standards reflect only the minimum level of staffing required and all LTC facilities must provide adequate staffing to meet their specific population's needs based on their facility assessments.

2. Medicaid Institutional Payment Transparency Reporting

Millions of Americans, including children and adults of all ages, receive Medicaid-covered long-term services and supports (LTSS) because of disabling conditions, chronic illness, and other factors. Medicaid is the largest payer nationally of LTSS. In 2019, 1.5 million Medicaid beneficiaries received nursing facility or intermediate care facility for individuals with intellectual disability (ICF/IID) services,[164] which accounted for over $61 billion in Medicaid expenditures, or 13 percent of the $478 billion in total Medicaid expenditures for that year.[165]

Through our regular interactions with State Medicaid agencies, provider groups, and beneficiary advocates, we have observed that all these interested parties routinely express the concern that understaffing in facilities and high rates of worker turnover of direct care workers make it difficult to have the sufficient workforce of well-trained and qualified staff needed to help ensure access to high-quality institutional services for people with disabilities and older adults. Further, demand for direct care workers is expected to continue rising due to the growing needs of the aging population.[166] [167]

As discussed in sections II. and III. of this proposed rule, anecdotal, quantitative, and qualitative evidence indicates that consistent, adequate direct care nurse staffing is vital to residents' health and safety. Worker turnover or understaffing also can reduce the efficiency of Medicaid payment for services, most clearly when the payment methodology is based on the actual cost of delivering services and such costs are increased due to reliance on overtime and temporary staff, which can have higher hourly costs than non-overtime wages paid to permanent staff. Further, understaffing can reduce quality of care, which can lead to poorer outcomes for people in institutional settings and result in costly emergency department visits and hospitalizations.[168] [169] [170] Accordingly, understaffing can reduce the cost-effectiveness of Medicaid institutional services.

In response to these concerns about the institutional workforce, we are proposing new Federal reporting requirements that are intended to promote public transparency around States' statutory obligation under section 1902(a)(30)(A) of the Act and around the quality requirements in section 1932(c) of the Act for services furnished through managed care

[160] Kelly LA, Gee PM, Butler RJ. Impact of nurse burnout on organizational and position turnover. Nurs Outlook. 2021 Jan-Feb;69(1):96–102. doi: 10.1016/j.outlook.2020.06.008. Epub 2020 Oct 4. PMID: 33023759; PMCID: PMC7532952.

[161] Ochieng, N., Chidambaram, P., Musumeci, M. Nursing Facility Staffing Shortages During the COVID–19 Pandemic. Apr 04, 2022. Kaiser Family Foundation. Accessed at *https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/*.

[162] Harrington, C., Carrillo, H., Garfield, R., Squires, E. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016. Apr 03, 2018. Kaiser Family Foundation. Accessed at *https://www.kff.org/report-section/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016-staffing-levels/*.

[163] Min A, Hong HC. Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A Cross-sectional study using the US Nursing Home Compare database. Geriatr Nurs. 2019 Mar-Apr;40(2):160–165. doi: 10.1016/j.gerinurse.2018.09.010. Epub 2018 Oct 4. PMID: 30292528.

[164] Kim, Min-Young, Edward Weizenegger, and Andrea Wysocki. *Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019.* Chicago, IL: Mathematica, July 22, 2022. Accessed at *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-user-brief-2019.pdf.* Disclaimer: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site after the date when we accessed them. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[165] Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019.* Chicago, IL: Mathematica, December 9, 2021. Accessed at *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.*

[166] Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[167] Centers for Medicare & Medicaid Services. November 2020. Long-Term Services and Supports Rebalancing Toolkit. Accessed at *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.*

[168] Ochieng, N., Chidambaram, P., Musumeci, M. Nursing Facility Staffing Shortages During the COVID–19 Pandemic. Apr 04, 2022. Kaiser Family Foundation. Accessed at *https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/*.

[169] Harrington, C., Carrillo, H., Garfield, R., Squires, E. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016. Apr 03, 2018. Kaiser Family Foundation. Accessed at *https://www.kff.org/report-section/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016-staffing-levels/*.

[170] Min A, Hong HC. Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A Cross-sectional study using the US Nursing Home Compare database. Geriatr Nurs. 2019 Mar-Apr;40(2):160–165. doi: 10.1016/j.gerinurse.2018.09.010. Epub 2018 Oct 4. PMID: 30292528.

organizations (MCOs) (as well as for prepaid inpatient health plans (PIHPs). We do so under our authority at section 1902(a)(4)), to make Medicaid payments that are sufficient to enlist enough providers so that high-quality LTSS are available to the beneficiaries who want and require such care. We are also relying on our authority under section 1902(a)(6) of the Act, which requires State Medicaid agencies to make such reports, in such form and containing such information, as the Secretary may from time to time require, and to comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports.

Specifically, we are proposing to require that State Medicaid agencies report annually, at the facility level and by delivery system (if applicable), on the portion of payments to nursing facility and ICF/IID services that are spent on compensation for the direct care and support staff workforce.[171] We are also proposing that States make this information available to the public by posting the information on a website. We are focusing on this compensation proposal because many direct care workers and support staff earn low wages and receive limited benefits.[172] Evidence suggests that there is a connection between wages and high rates of turnover among some workers in the institutional workforce.[173] In order to develop relevant policies to support high quality care for Medicaid beneficiaries, we first need clear, consistent data from States and facilities about the current percent of Medicaid payments going to the compensation of direct care workers and support staff. Data regarding the percent of Medicaid payments going to compensation of direct care workers and support staff is not currently being reported to CMS.

B. Overall Impacts

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA, September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 1995; Pub. L. 104–4), and Executive Order 13132 on Federalism (August 4, 1999).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 14094 entitled ''Modernizing Regulatory Review'' (hereinafter, the Modernizing E.O.) amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $200 million or more in any 1 year (adjusted every 3 years by the Administrator of OIRA for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for regulatory actions with significant effects as per section 3(f)(1) ($200 million or more in any 1 year). Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

For this proposed rule, we have calculated the annual cost of the proposed minimum staffing requirements in Table 20 hours based on hours per resident day in CY 2021 dollars, assuming the implementation and enforcement of these requirements as being applied independent of a facility's case-mix. We estimate that the aggregate impact of the staffing-related provisions proposed in this rule, which includes a phased-in implementation of a requirement for 24 hours per day, 7 days per week RN onsite coverage, as well as the 0.55 RN and 2.45 NA minimum HPRD requirements, will result in an estimated cost of approximately $32 million in year 1, $246 million in year 2, $4.06 billion in year 3, with costs increasing to $5.7 billion by year 10. We estimate the total cost over 10 years will be $40.6 billion with an average annual cost of $4.06 billion.

Additionally, we have estimated in Table 30 the economic impact of the proposed requirement that States report, by facility and by delivery system (if applicable), on the percentage of Medicaid payments being spent on compensation for direct care workers and support staff delivering Medicaid-covered nursing facility and ICF/IID services. We are proposing that these requirements would become effective 4 years after finalization. We estimate an initial implementation cost of $9,355,472 for years 1 to 4 (resulting in total initial implementation costs of $37,421,886) and ongoing annual costs of $18,305,713 per year starting in year 5.

C. Detailed Economic Analysis

1. Impacts for LTC Minimum Staff Requirement

a. Nursing Services (§ 483.35)

We are proposing to make two changes to the existing requirements for Nursing Services for LTC facilities at § 483.35. We are proposing to require facilities to provide RN coverage onsite 24 hours per day, 7 days a week and to meet a minimum staffing standard of 0.55 RN and 2.45 NA HPRD. We note that these estimates do not include the exemption criteria, which could reduce the rule's cost (including cost associated with potential LTC facility closure or reduction in patient load capacity per facility) and benefits, based on the use of exemptions.

(1) RN On Site 24 Hours a Day, 7 Days a Week (24/7 RN)

To estimate the cost to the industry for the RN on site 24 hours a day, 7 days a week (24/7 RN) requirement we first summed the current annual RN salary cost for each facility. We then subtracted this amount from the estimated annual RN salary cost that the facility will incur to meet the new requirement.

To measure the current RN staff cost to the industry, we estimated the total number of RNs currently employed in LTC facilities and their loaded

[171] Throughout this discussion, we use the term ''States'' to include all States, Washington, DC, and any territories that include nursing facility services or ICF/IID services in their State plan.

[172] Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[173] Sharma, H. and Liu, X. Association between wages and nursing staff turnover in Iowa. Innov Aging. 2022; 6(4): igac004. Published online 2022 Feb 5. doi: *10.1093/geroni/igac004.*

respective labor wages using data from the 2022 Nursing Home Staffing Study, which has information on 14,688 LTC facilities. This study uses the *2021 SNF—Medicare Cost Report* data set to find the total facilities, the total number of reported LTC specific RNs and their loaded annual salaries, defined as salary and fringe benefits. Using this dataset, we were able to estimate the aggregate RN loaded salary costs and the cost per facility.

To estimate the RN cost per resident census, we used the October 2021 *Care Compare* data set that calculates average hours per resident day (HPRD) for RNs using the PBJ System data from 2021 Q2. Hours per resident day is defined as the average hours of RN care that each resident in the facility receives per day. For example, a facility that has an average HPRD of 0.5 for RNs would provide, on average, 0.5 hours (30 minutes) of RN care for each resident. We linked this dataset using the facility unique ID variable with the *2021 SNF—Medicare Cost Report* data set to create a complete dataset. Using this combined dataset, we were also able to view the impact by resident census as well as the impact by LTC facility characteristics such as facility ownership, bed size, Five-Star Quality Rating System staffing ratings, payer mix, and location. This complete dataset helped provide an understanding of which types of LTC facilities would bear the largest cost burden of a new Federal 24/7 RN requirement.

For each facility, we first calculated the total number of hours each day that an RN is on site by multiplying the average RN hours per resident day by the average number of residents in the facility (daily hours of RN care = RN HPRD × Residents in Facility). We then estimated the number of additional hours of RN care that facility would need to meet the 24/7 RN requirement by subtracting the current daily hours of RN care from 24 hours (additional daily RN hours needed = 24 − current daily hours of RN care). We then calculated the total number of additional RN hours needed per year by multiplying this amount by 365 (additional yearly RN hours needed = additional daily RN hours needed × 365). Finally, we estimated each facility's yearly cost for meeting the requirement by multiplying the total number of the yearly hours needed by the loaded hourly wage (yearly 24/7 RN cost = additional yearly RN hours needed × facility RN wage rate).

For example, if a facility had an average of 0.4 RN HPRD and had 50 residents it would provide 20 hours of total RN hours per day (0.4 HPRD × 50 residents = 20 total RN hours per day). To meet the 24/7 RN requirement, this facility would have to increase its total RN hours per day by 4 hours (24 hours needed − 20 hours current RN care = 4 hours needed) and 1,460 hours (4 hours per day × 365 days/year) annually. Using the loaded hourly wage cost of $44 per hour, this facility would spend $64,240 per year ($44 × 4 RN hours per day × 365 day per year = $64,240) to be in compliance with the 24/7 RN requirement.

After estimating each facility's cost for meeting the 24/7 RN requirement, the next step was to sum the additional cost for all LTC facilities to meet the 24/7 RN requirement for an aggregate cost to the industry of $349 million per year. We also found approximately 78 percent of LTC facilities had 24/7 RN coverage within a 90-day window based on PBJ System data from 2021 Q2 showing that they provided at least 24 hours of RN care per day. We assumed this estimate for all quarters, for an annual estimate of approximately 22 percent (100 percent − 78 percent = 22 percent) or 3,261 LTC facilities (0.222 × 14,688 LTC facilities = 3,261 LTC facilities) that would need to increase their RN staffing to comply with the 24/7 RN requirement. Among this 22 percent of facilities needing to increase RN staffing, there was an average of 0.43 hours of RN care per resident day.

Table 15 summarizes the average annual cost for LTC facilities to meet the 24/7 RN Staffing Requirement over a 10-year period, which includes any associated collection of information costs as described in section IV. In estimating the cost, we take into account expected growth in wages that will result from greater demand for RNs in LTC facilities to meet this proposed 24/7 RN requirement, as well as the 0.55 RN hours per resident day requirement that we discuss in more detail later in the analysis. All costs are reflected in 2021 US dollars.

There is uncertainty about how much RN wages will change over the next 10 years due to changes in demand for RNs emerging due to both this proposed rule, as well as broader patterns of healthcare use in the United States. A 2009 study [174] examined minimum licensed nurse (RN/LPN) staffing standards in California for acute care hospitals that went into effect in March 2004. The authors found that compared to metropolitan areas outside of California that did not have the regulation, RN wage growth in California increased 12.8 percent more between 2000 and 2006. A more recent study [175] found that real nurse wage rates increased by nearly 10 percent between 2001 and 2017, with changes in rates varying during years of U.S. economic growth and recession. During its strongest growth between 2001 and 2004, real wages increased at an average rate of 2.41 percent annually. Given the uncertainty in growth and increased demands for RNs, we assumed that real wages each year would increase at 2.31 percent.

We provide separate cost estimates for facilities in rural and urban areas since facilities in rural areas would have to meet the requirement 3 years after the final rule publication. Facilities in urban areas, in contrast, would need to meet the requirement 2 years after the final rule publication. This resulted in an average annual cost of approximately $347 million in 2021 US dollars without considering exemptions.

TABLE 15—ANNUAL COST FOR 24/7 RN REQUIREMENT

Year	Collection of information costs for 24/7 RN (§ 483.35 nursing services)	24/7 RN requirement (urban facilities)	24/7 RN requirement (rural facilities)	Total cost
1	$7,461,504.00	$0.00	$0.00	$7,461,504.00
2	7,633,864.74	213,764,107.41	0.00	221,397,972.15
3	7,810,207.02	218,702,058.29	146,603,030.04	373,115,295.34

[174] Mark B, Harless DW, and Spetz J. Spetz. California's Minimum-Nurse Staffing Legislation and Nurses' Wages Health Affairs. 2009;28 Supplement 1, w326–w334. *doi: 10.1377/hlthaff.28.2.w326.*

[175] Barry J. Real wage growth in the U.S. health workforce and the narrowing of the gender pay gap. Human Resources for Health. 2021;19: 105. *doi: 10.1186/s12960–021–00647–3.*

TABLE 15—ANNUAL COST FOR 24/7 RN REQUIREMENT—Continued

Year	Collection of information costs for 24/7 RN (§ 483.35 nursing services)	24/7 RN requirement (urban facilities)	24/7 RN requirement (rural facilities)	Total cost
4	7,990,622.80	223,754,075.83	149,989,560.03	381,734,258.67
5	8,175,206.19	228,922,794.98	153,454,318.87	390,552,320.04
6	8,364,053.45	234,210,911.55	156,999,113.64	399,574,078.64
7	8,557,263.08	239,621,183.61	160,625,793.16	408,804,239.85
8	8,754,935.86	245,156,432.95	164,336,248.98	418,247,617.79
9	8,957,174.88	250,819,546.55	168,132,416.34	427,909,137.76
10	9,164,085.62	256,613,478.07	172,016,275.15	437,793,838.85
10 Year Total Cost	82,868,918	2,111,564,589	1,272,156,756	3,466,590,263.09

We are soliciting comments on our assumptions, particularly our assumption that real wage rates for RNs will increase at annual rate of 2.31 percent, and burden estimates. We are also soliciting comments on how the available supply of RNs and potential changes in this supply and demand across different geographical areas over the next 10 years may influence the rule's cost for LTC facilities and other health care providers competing for the same supply of RNs.

(2) RN On Site 24 Hours a Day, 7 Days a Week (24/7 RN)—State Level Analysis

To provide a more in-depth understanding of the financial and staffing effects of the 24/7 RN proposed requirement, we examined its impact for different groups of LTC facilities in each State, as well as Washington DC and Puerto Rico. We first assessed how many full-time RNs LTC facilities would need to hire to meet the proposed requirement. In this analysis, we defined a full-time employee as an employee who worked 1,950 hours per year. This definition was based on a full-time employee working 5 days per week, 8 hours per day, with a 30-minute break (37.5 hours/week × 52 weeks/year). To meet the 24/7 RN requirement, each facility would need to provide a minimum of 8,760 hours (24 hours/day × 365 days) of RN care annually since we did not include any facility exemptions in these calculations. All calculations used the October 2021 *Care Compare* data set that provides each LTC facility's average daily resident census and HPRD for RNs using the PBJ System data from 2021 Q2.

For each facility, we first calculated the total number of full-time RNs in the facility using the following formula: (facility specific RN HPRD × average daily resident census × 365)/1,950. For example, if a facility had 100 residents and provided an average of 0.2 RN HPRD, then during the year, it will provide a total of 7,300 hours of RN care (0.2 RN HPRD × 100 residents × 365 days = 7,300 hours) yearly and have 3.74 full-time RNs. We then calculated the number of additional full-time RNs needed by subtracting the total hours of RN care that the facility currently provides yearly from the 8,760 hours needed to ensure 24/7 RN coverage and dividing by 1,950, which is the number of hours of yearly care provided by a full-time RN. Continuing with our example in this section, the LTC facility would need to provide 1,460 additional RN hours per year (8,760 hours − 7,300 hours = 1,460 hours) and hire 0.75 additional full-time RNs.

Table 16 shows the total number of RNs currently employed by LTC facilities in each State's urban and rural areas, the number of full-time RNs and NAs that LTC facilities would need to hire, and the percent increase in RNs that LTC facilities in each State would need to meet the proposed minimum staffing standard barring any exemptions. Oklahoma would need the largest increase in RNs in percentage terms for rural facilities, needing to increase the size of its RN workforce by 27 percent. Meanwhile, for urban facilities, the largest percentage increase in RNs would be in Louisiana at 17.6 percent. Facilities in Texas would need to hire the most overall RNs with the State needing 653 additional full-time RNs. Across the United States, however, the number of RNs that facilities would need to meet the requirement varies widely with several States, including Florida and Illinois, needing to increase the size of their LTC facilities' RN labor force by less than 1 percent.

TABLE 16—CURRENT AND ADDITIONAL FULL-TIME RNS NEEDED PER STATE TO MEET THE 24/7 RN REQUIREMENT

[Absent an exemption]

State	Existing full-time RNs in rural areas	Additional RNs needed in rural areas	Percent increase in RNs needed in rural areas	Existing full-time RNs in urban areas	Additional RNs needed in urban areas	Percent increase in RNs needed in urban areas
Alabama	721	6	0.8	1,416	12	0.8
Alaska	108	2	1.9	108	0	0.0
Arizona	60	1	1.7	1,247	12	1.0
Arkansas	487	50	10.3	559	64	11.5
California	150	20	13.3	9,461	280	3.0
Colorado	374	17	4.5	2,026	0	0.0
Connecticut	118	1	0.8	2,145	2	0.1
Delaware	0	0	.....	648	1	0.2
District of Columbia	0	0	.....	468	0	0.0
Florida	286	8	2.8	8,208	21	0.3
Georgia	732	66	9.0	1,469	58	3.9
Hawaii	177	1	0.6	743	0	0.0
Idaho	163	8	4.9	437	5	1.1
Illinois	1,049	68	6.5	5,965	55	0.9
Indiana	1,147	46	4.0	2,611	74	2.8

TABLE 16—CURRENT AND ADDITIONAL FULL-TIME RNS NEEDED PER STATE TO MEET THE 24/7 RN REQUIREMENT—Continued

[Absent an exemption]

State	Existing full-time RNs in rural areas	Additional RNs needed in rural areas	Percent increase in RNs needed in rural areas	Existing full-time RNs in urban areas	Additional RNs needed in urban areas	Percent increase in RNs needed in urban areas
Iowa	1,458	99	6.8	1,254	37	3.0
Kansas	862	71	8.2	1,054	38	3.6
Kentucky	1,212	8	0.7	1,249	9	0.7
Louisiana	262	49	18.7	762	134	17.6
Maine	403	8	2.0	576	4	0.7
Maryland	125	0	0.0	2,939	9	0.3
Massachusetts	12	0	0.0	3,973	29	0.7
Michigan	1,299	12	0.9	3,050	32	1.0
Minnesota	1,218	19	1.6	2,968	14	0.5
Mississippi	982	21	2.1	509	16	3.1
Missouri	823	114	13.9	1,707	114	6.7
Montana	356	15	4.2	163	6	3.7
Nebraska	630	58	9.2	743	4	0.5
Nevada	61	4	6.6	667	0	0.0
New Hampshire	349	1	0.3	388	7	1.8
New Jersey	0	0	.....	4,756	22	0.5
New Mexico	256	8	3.1	324	4	1.2
New York	827	5	0.6	10,277	21	0.2
North Carolina	800	19	2.4	2,381	46	1.9
North Dakota	386	9	2.3	313	0	0.0
Ohio	1,681	74	4.4	5,169	142	2.7
Oklahoma	437	118	27.0	568	83	14.6
Oregon	158	5	3.2	762	29	3.8
Pennsylvania	1,026	1	0.1	7,575	9	0.1
Puerto Rico	0	0	.....	29	0	0.0
Rhode Island	0	0	.....	947	0	0.0
South Carolina	279	8	2.9	1,325	26	2.0
South Dakota	488	19	3.9	240	4	1.7
Tennessee	683	28	4.1	1,693	25	1.5
Texas	1,138	250	22.0	4,451	403	9.1
Utah	122	2	1.6	926	8	0.9
Vermont	250	4	1.6	72	1	1.4
Virginia	574	6	1.0	1,951	22	1.1
Washington	193	3	1.6	1,967	5	0.3
West Virginia	399	10	2.5	682	2	0.3
Wisconsin	1,142	11	1.0	2,214	20	0.9
Wyoming	245	5	2.0	85	0	0.0
United States	26,708	1,358	5.1	108,220	1,909	1.8

We then assessed the financial cost for facilities to implement the proposed 24/7 RN requirement. To estimate the yearly cost per State, we used the formulas described in section VI.C.1.a.(1) of this proposed rule to first estimate each facility's yearly cost to meet the requirement. We also assumed that LTC facilities exceeding the minimum requirements for RNs would not reduce RNs to the minimum required level or lay off other staff to reduce costs. We then calculated the average cost per resident day by summing the total cost of meeting the requirement for all facilities in the State and dividing it by the total number of resident days for *all facilities needing additional RNs.* We estimated the average cost per resident day only for facilities needing staff to provide a more complete picture of the burden that the rule would impose on these facilities.

Table 17 provides the yearly Statewide cost to implement the requirement, as well as the average cost per resident day for facilities in rural and urban areas that would need to hire additional RN to meet the requirement. Delaware would have the highest cost per resident day with a single facility that is not meeting the 24/7 RN requirement and would need to spend $87.45 per resident day. The highest overall cost occurs in Texas where facilities would need to collectively spend more than $84 million to meet the minimum staffing requirement. The cost also varied across urban and rural areas. In New Hampshire, LTC facilities in urban areas that need staff would need to spend an average of $8.95 per resident day to meet the requirement, while in Hawaii, Puerto Rico, and Wyoming these facilities would incur no cost. Nevada would have the highest average cost for rural LTC facilities at $21.81 per resident day.

TABLE 17—LTC FACILITIES IN EACH STATE NEEDING RNS AND THE AVERAGE COST PER RESIDENT DAY BY RURAL AND URBAN LOCATION TO SATISFY 24/7 RN REQUIREMENT

[Absent an exemption]

State	Yearly statewide cost ($ million)	Average cost per resident day (statewide)	Urban LTC facilities needing RNs	Average cost per resident day (urban areas)	Rural LTC facilities needing RNs	Average cost per resident day (rural areas)
Alabama	1.1	$3.25	12	$3.86	6	$2.14
Alaska	0.2	20.75	0	0.00	2	20.75
Arizona	1.1	5.09	12	5.80	1	0.28

TABLE 17—LTC FACILITIES IN EACH STATE NEEDING RNS AND THE AVERAGE COST PER RESIDENT DAY BY RURAL AND URBAN LOCATION TO SATISFY 24/7 RN REQUIREMENT—Continued

[Absent an exemption]

State	Yearly statewide cost ($ million)	Average cost per resident day (statewide)	Urban LTC facilities needing RNs	Average cost per resident day (urban areas)	Rural LTC facilities needing RNs	Average cost per resident day (rural areas)
Arkansas	8.8	3.62	64	3.00	50	4.59
California	44.5	7.96	280	7.81	20	10.42
Colorado	1.8	9.13	0	0.00	17	9.13
Connecticut	0.2	6.24	2	1.22	1	19.09
Delaware	0.3	87.45	1	87.45	0	0.00
District of Columbia	0.0	0.00	0	0.00		
Florida	2.4	5.04	21	4.92	8	5.31
Georgia	13.0	4.91	58	4.54	66	5.27
Hawaii	0.1	10.08	0	0.00	1	10.08
Idaho	0.9	6.34	5	8.38	8	5.04
Illinois	14.4	6.95	55	6.15	68	7.86
Indiana	10.9	5.87	74	5.16	46	7.48
Iowa	10.0	6.18	37	5.37	99	6.51
Kansas	9.0	7.14	38	6.72	71	7.41
Kentucky	1.2	4.63	9	3.01	8	7.12
Louisiana	23.1	4.43	134	4.16	49	5.34
Maine	0.8	6.55	4	5.55	8	7.19
Maryland	0.6	6.20	9	6.20	0	0.00
Massachusetts	3.1	7.23	29	7.23	0	0.00
Michigan	4.2	5.38	32	5.89	12	3.69
Minnesota	1.6	5.05	14	5.91	19	4.39
Mississippi	2.3	3.68	16	3.81	21	3.57
Missouri	23.5	5.83	114	5.29	114	6.46
Montana	1.7	6.16	6	4.62	15	6.96
Nebraska	5.6	8.28	4	5.50	58	8.47
Nevada	0.7	21.81	0	0.00	4	21.81
New Hampshire	0.8	8.54	7	8.95	1	6.61
New Jersey	1.7	4.41	22	4.41	0	0.00
New Mexico	0.8	5.00	4	4.57	8	5.34
New York	2.7	5.57	21	5.35	5	6.75
North Carolina	5.6	4.63	46	5.15	19	3.51
North Dakota	0.7	6.94	0	0.00	9	6.94
Ohio	17.9	4.94	142	4.83	74	5.23
Oklahoma	26.2	7.77	83	6.85	118	8.54
Oregon	3.7	8.78	29	8.43	5	11.97
Pennsylvania	0.7	5.75	9	7.44	1	1.65
Puerto Rico	0.0	0.00	0	0.00	0	0.00
South Carolina	2.8	4.77	26	4.73	8	4.93
South Dakota	1.6	5.62	4	7.36	19	5.23
Tennessee	4.2	4.13	25	4.32	28	3.94
Texas	84.6	6.28	403	5.48	250	7.95
Utah	0.7	4.98	8	5.79	2	1.83
Vermont	0.3	5.42	1	0.65	4	5.97
Virginia	2.1	3.92	22	3.87	6	4.12
Washington	0.8	6.76	5	7.00	3	6.41
West Virginia	1.1	6.52	2	5.81	10	6.62
Wisconsin	2.6	7.30	20	7.42	11	7.10
Wyoming	0.4	8.60	0	0.00	5	8.60
United States	349.0	5.97	1,909	5.55	1,358	6.71

Table 18 shows the average cost per resident day to implement the requirement for facilities in each State that would need additional RNs, dividing facilities based on their size into three groups: less than 50 beds, 50 to 100 beds, and more than 100 beds. Within each group of LTC facilities, the cost varied widely by number of beds and State. In West Virginia, the average cost per resident day for facilities that have more than 100 beds and need additional RNs would be $0.72, while in North Carolina, the average cost per resident day for facilities with fewer than 50 beds would be $29.19.

TABLE 18—NUMBER OF LTC FACILITIES IN EACH STATE NEEDING TO HIRE RNS AND AVERAGE COST PER RESIDENT DAY BY FACILITY SIZE TO SATISFY 24/7 RN REQUIREMENT

[Absent an exemption]

State	LTC facilities needing RNs	Yearly statewide cost ($ million)	Average cost per resident day (statewide)	Cost – <50 beds	Cost – 50 to 100 beds	Cost >100 beds
Alabama	18	$1.10	$3.25	$0.94	$3.59	$2.09
Alaska	2	0.20	20.75	20.75	0.00	0.00
Arizona	13	1.10	5.09	11.17	5.02	4.23
Arkansas	114	8.80	3.62	0.00	4.63	2.75
California	300	44.50	7.96	17.35	6.39	3.33

TABLE 18—NUMBER OF LTC FACILITIES IN EACH STATE NEEDING TO HIRE RNS AND AVERAGE COST PER RESIDENT DAY BY FACILITY SIZE TO SATISFY 24/7 RN REQUIREMENT—Continued

[Absent an exemption]

State	LTC facilities needing RNs	Yearly statewide cost ($ million)	Average cost per resident day (statewide)	Cost – <50 beds	Cost – 50 to 100 beds	Cost >100 beds
Colorado	17	1.80	9.13	15.46	5.82	5.67
Connecticut	3	0.20	6.24	14.21	0.00	0.52
District of Columbia	0	0.00	0.00	0.00	0.00	0.00
Delaware	1	0.30	87.45	0.00	87.45	0.00
Florida	29	2.40	5.04	11.73	4.14	2.25
Georgia	124	13.00	4.91	13.29	5.37	3.42
Hawaii	1	0.10	10.08	10.08	0.00	0.00
Idaho	13	0.90	6.34	7.54	4.57	6.57
Illinois	123	14.40	6.95	13.93	8.19	4.02
Indiana	120	10.90	5.87	12.74	5.69	2.33
Iowa	136	10.00	6.18	7.92	4.85	2.24
Kansas	109	9.00	7.14	8.26	5.75	2.62
Kentucky	17	1.20	4.63	3.37	5.41	0.16
Louisiana	183	23.10	4.43	10.25	7.00	3.85
Maine	12	0.80	6.55	6.55	6.56	0.00
Maryland	9	0.60	6.20	6.96	2.13	0.00
Massachusetts	29	3.10	7.23	12.58	7.42	2.06
Michigan	44	4.20	5.38	11.66	4.50	2.81
Minnesota	33	1.60	5.05	5.61	3.97	0.00
Mississippi	37	2.30	3.68	9.72	3.25	1.50
Missouri	228	23.50	5.83	11.26	7.32	3.61
Montana	21	1.70	6.16	12.26	3.78	8.19
Nebraska	62	5.60	8.28	10.60	6.54	4.94
Nevada	4	0.70	21.81	24.40	17.35	0.00
New Hampshire	8	0.80	8.54	12.34	6.50	4.07
New Jersey	22	1.70	4.41	16.27	2.60	2.06
New Mexico	12	0.80	5.00	7.70	4.13	5.28
New York	26	2.70	5.57	6.83	7.70	1.77
North Carolina	65	5.60	4.63	29.19	3.66	1.52
North Dakota	9	0.70	6.94	6.42	11.09	0.00
Ohio	216	17.90	4.94	9.75	4.33	3.71
Oklahoma	201	26.20	7.77	18.00	9.45	5.09
Oregon	34	3.70	8.78	12.43	7.35	9.33
Pennsylvania	10	0.70	5.75	9.19	3.19	1.65
Puerto Rico	0	0.00	0.00	0.00	0.00	0.00
South Carolina	34	2.80	4.77	10.48	4.78	1.76
South Dakota	23	1.60	5.62	7.27	2.54	0.00
Tennessee	53	4.20	4.13	12.27	4.54	2.01
Texas	653	84.60	6.28	10.93	8.11	5.01
Utah	10	0.70	4.98	3.58	6.01	0.00
Vermont	5	0.30	5.42	9.82	2.01	0.00
Virginia	28	2.10	3.92	12.31	3.44	0.73
Washington	8	0.80	6.76	14.04	6.41	1.42
West Virginia	12	1.10	6.52	13.74	3.98	0.72
Wisconsin	31	2.60	7.30	13.32	5.52	9.19
Wyoming	5	0.40	8.60	17.49	2.22	0.00
United States	1,850	349.0	5.97	11.17	6.25	4.07

In Table 19, we calculated the average cost by State for facilities needing staff to meet the minimum staffing requirement based on whether the facility accepted patients with Medicare, Medicaid, or both Medicare and Medicaid. The highest per resident day cost would be for 14 Medicaid-only facilities in Illinois that would need to spend an average of $29 per resident day to meet the staffing requirement. The lowest per resident day cost for facilities needing staff would be for a single Medicaid-only facility in South Dakota that would need to spend $0.33 per resident day to meet the requirement.

TABLE 19—NUMBER OF LTC FACILITIES IN STATE NEEDING TO HIRE STAFF AND AVERAGE COST PER RESIDENT DAY BY MEDICARE, MEDICAID, AND DUAL ACCEPTANCE STATUS TO SATISFY 24/7 RN REQUIREMENT

[Absent exemption]

State	Medicaid only facilities needing RNs	Medicaid only facilities cost per resident day	Medicare only facilities needing RNs	Medicare only facilities cost per resident day	Medicare and Medicaid facilities needing RNs	Medicare and Medicaid facilities cost per resident day
Alabama	2	$5.10	1	$0.94	15	$3.14
Alaska	0	0.00	0	0.00	2	20.75
Arizona	0	0.00	2	34.70	10	3.75
Arkansas	1	3.76	0	0.00	111	3.61
California	11	9.11	13	20.26	273	7.54
Colorado	3	23.37	0	0.00	13	6.41

TABLE 19—NUMBER OF LTC FACILITIES IN STATE NEEDING TO HIRE STAFF AND AVERAGE COST PER RESIDENT DAY BY MEDICARE, MEDICAID, AND DUAL ACCEPTANCE STATUS TO SATISFY 24/7 RN REQUIREMENT—Continued
[Absent exemption]

State	Medicaid only facilities needing RNs	Medicaid only facilities cost per resident day	Medicare only facilities needing RNs	Medicare only facilities cost per resident day	Medicare and Medicaid facilities needing RNs	Medicare and Medicaid facilities cost per resident day
Connecticut	0	0.00	0	0.00	3	6.24
Delaware	0	0.00	1	87.45	0	0.00
District of Columbia	0	0.00	0	0.00	0	0.00
Florida	0	0.00	2	10.71	24	3.81
Georgia	1	26.52	2	34.37	121	4.75
Hawaii	0	0.00	0	0.00	1	10.08
Idaho	0	0.00	1	1.86	12	6.68
Illinois	10	5.35	0	0.00	113	7.10
Indiana	4	7.88	2	20.15	112	5.50
Iowa	2	5.26	1	12.90	129	6.09
Kansas	19	10.72	0	0.00	89	6.52
Kentucky	0	0.00	1	0.68	15	4.78
Louisiana	0	0.00	6	6.74	170	4.48
Maine	0	0.00	0	0.00	10	5.38
Maryland	0	0.00	4	7.68	4	5.23
Massachusetts	0	0.00	2	10.03	25	6.58
Michigan	1	14.48	0	0.00	42	5.42
Minnesota	3	8.26	0	0.00	28	4.75
Mississippi	5	4.45	1	23.67	31	3.31
Missouri	6	11.30	2	3.08	219	5.68
Montana	0	0.00	0	0.00	21	6.16
Nebraska	5	13.34	0	0.00	53	7.28
Nevada	0	0.00	0	0.00	4	21.81
New Hampshire	0	0.00	0	0.00	8	8.54
New Jersey	0	0.00	2	5.28	19	4.38
New Mexico	1	5.96	0	0.00	11	4.95
New York	0	0.00	0	0.00	26	5.57
North Carolina	0	0.00	8	70.04	56	3.24
North Dakota	0	0.00	0	0.00	9	6.94
Ohio	0	0.00	4	12.33	208	4.81
Oklahoma	5	18.96	1	0.01	191	7.58
Oregon	3	4.27	2	23.40	29	8.89
Pennsylvania	0	0.00	2	21.85	8	3.66
Puerto Rico	0	0.00	0	0.00	0	0.00
Rhode Island	0	0.00	0	0.00	0	0.00
South Carolina	0	0.00	10	12.96	23	3.43
South Dakota	4	5.18	0	0.00	19	5.70
Tennessee	4	14.91	2	4.78	47	3.51
Texas	14	9.00	11	9.40	620	6.18
Utah	2	3.04	1	8.08	7	5.34
Vermont	0	0.00	0	0.00	5	5.42
Virginia	4	7.68	3	2.82	20	2.88
Washington	0	0.00	0	0.00	8	6.76
West Virginia	3	19.82	0	0.00	7	5.00
Wisconsin	1	26.97	2	12.89	27	6.73
Wyoming	0	0.00	0	0.00	5	8.60
United States	114	9.22	89	13.44	3,003	5.72

(3) Minimum Nurse Staffing Requirement of at Least 0.55 RN and 2.45 NA HPRD

To estimate the incremental impact of the minimum nurse staffing requirement of 0.55 RN and 2.45 NA HPRD, we first estimated the industry's aggregate annual cost for nurse staff (RNs, LPNs/LVNS, and NAs) at current staffing levels. We then estimated the aggregate annual cost for nurse staff (RNs, LPNs/LVNs, and NAs) for all facilities to meet the minimum requirement. As discussed above, we note that the minimum staffing requirements are applied independent of a facility's individual case-mix, meaning the expected costs to a facility are based solely on the cost of facilities adding additional staff to meet the 0.55 RN and 2.45 NA HPRD based on the facility's current staffing data, regardless of the facility's case-mix. Finally, we calculated the requirement's expected cost to the industry by subtracting the industry's current nurse staff cost from the estimated nurse staff cost for all facilities to meet the minimum requirement (Nurse Staff Cost for All Facilities to Meet Minimum Requirement—All Facilities' Current Nurse Staff Cost). To measure the current nurse staffing cost to the industry, we estimated the total number of nurse staff currently employed in LTC facilities and their loaded respective labor wages. This study used the *2021 SNF—Medicare Cost Report* dataset to find the total of facilities, the total number of reported LTC specific nurse-type staff and their loaded annual salaries, defined as salary and fringe benefits. Using this dataset, we were able to estimate the aggregate total nurse staffing salary costs and the cost per facility.

To estimate the nurse staffing cost by staff type, that is, RNs, LPNs/LVNs, NAs, per resident census we used the October 2021 *Care Compare* data set that calculates average hours per resident day (HPRD) for each nurse type using the PBJ System data from 2021 Q2. Hours per resident day was defined as the average hours of care that each resident in the facility receives from that nurse type. For example, a facility that

had an average HPRD of 0.5 for RNs would provide, on average, 0.5 hours (30 minutes) of RN care for each resident. We linked this dataset using the facility unique ID variable with the *2021 SNF—Medicare Cost Report* data set to create a complete dataset. Using this combined dataset, we were also able to view the impact by staff type per resident census as well as the impact by LTC facility characteristics such as facility ownership, bed size, Five-Star Quality Rating System staffing ratings, payer mix, and location. This complete dataset helped provide an understanding of which types of LTC facilities would bear the largest cost burden of a new Federal minimum staffing requirement.

Using the above dataset, we estimated each facility's current total annual salary costs for each nurse type (RN, LPN/LVN, NA) as follows: [facility specific nurse type] loaded hourly wage × [facility specific nurse type] reported HPRD × facility-level average daily facility resident census × 365. For example, if a facility reported an average loaded hourly wage of $44 for its RNs, an average of 0.4 RN HPRD, and an average daily resident census of 100, its estimated annual salary costs for RNs would be calculated as: $44 × 0.4 × 100 × 365 = $642,400. Taking this example further, if this same facility reported a loaded average hourly wage of $21 for its NAs, an average of 2.1 NA HPRD, and an average daily resident census of 100, its estimated annual salary costs for NAs would be calculated as: $21 × 2.1 × 100 × 365 = $1,609,650. If this facility only employed RNs and NAs as part of its total nurse staff, then the facility's current total nurse staff cost would be $2,252,050 ($642,400 + $1,609,650 = $2,252,050). To estimate the aggregate current nurse staff cost across all facilities, the next step was to sum all facilities' current total (RN, LPN/LVN, and NA) nurse staff cost for an overall industry nurse staff cost of $43.4 billion.[176] To estimate the cost of the minimum nurse staffing requirement, we subtracted the total current nurse staff cost per facility from the total nurse staff cost per facility with the minimum nurse staffing standard. The formula applied to calculate each facility's cost of meeting the requirement per specific nurse type was: [facility specific nurse type] hourly wage × [[facility specific nurse type] required HPRD − [facility specific nurse type] reported HPRD] × facility level average daily resident census × 365. Using the same LTC facility example from the paragraph above where the facility had an average of 0.4 RN HPRD and 2.1 NA HPRD, for this LTC facility to comply it would need to increase its RN HPRD from 0.4 to 0.55 and NA HPRD from 2.1 to 2.45. The cost for this requirement on this facility would thus be $509,175 (($44 × (0.55 − 0.4) × 100 × 365) + ($21 × (2.45 − 2.1) × 100 × 365) = $509,175).

When LTC facilities hire RNs to meet the 24/7 RN requirement, the hours these RNs work will also count toward the 0.55 RN HPRD requirement. To avoid overestimating the number of RNs that LTC facilities will need to hire and the cost to hire them, if a LTC facility has less than 0.55 RN HPRD, we subtracted any cost that the facility would incur to meet the 24/7 RN requirement up to the point where the LTC facility will meet the 0.55 RN HPRD requirement using the following formula: [facility specific cost to meet 0.55 RN and 2.45 NA HPRD Requirement] − [Facility Cost to Meet 24/7 RN Requirement].

Once we apply this formula to each facility in our dataset, we summed each facility's total cost to obtain the requirement cost to the industry of approximately $4.23 billion.

This $4.23 billion estimate assumed that LTC facilities would respond to the minimum nurse staffing requirement by increasing their RN and their NA staffing levels to the minimum necessary levels, without reducing other staff, such as administrative staff. We also assumed that LTC facilities would not obtain exemptions from the minimum staffing requirement. Finally, we assumed LTC facilities that were above the minimum staffing requirements for RNs and NAs would not decrease their current staffing levels and that owners of LTC chain facilities would not shift staff from facilities above the minimum proposed requirement to facilities below the minimum proposed requirement.[177]

If LTC facilities covered under this proposed rule reduced other staff not covered by the rule, owners of LTC chain facilities shifted RN and NAs to other facilities below the requirements, or if LTC facilities obtained exemptions from the minimum staffing requirements the $4.23 billion estimate may decline significantly. Any reduction in other staff, however, could also impose costs on residents due to reductions in support activities, such as housekeeping and food service, that contribute to quality of life in the LTC facility. As such, we seek comments on all the assumptions used in these cost models.

Table 20 summarizes the estimated total cost for the comprehensive minimum nurse staffing requirement which includes any associated collection of information costs as described in section IV. Collection of Information Requirements, but not the regulatory review costs which we discuss in more detail later in this section. To account for real growth in RN and NA wages over time, we used the same assumption that we used to estimate the cost of the 24/7 RN requirement. More specifically, we assumed that real wages for RNs and NAs needed to meet the proposed 0.55 RN and 2.45 HPRD requirement, as well as collection of information costs, would increase at 2.31 percent annually. Since rural and urban LTC facilities have different phase-in periods to meet the 24/7 RN (2 years for facilities in urban areas and 3 years for facilities in rural areas) and the 0.55 RN and 2.45 NA HPRD requirements (3 years for facilities in urban areas and 5 years for facilities in rural areas) we provided separate cost estimates for facilities located in each area. Over a 10-year period, we anticipate an average annual cost of approximately $4.06 billion.

[176] Calculated as the sum of reported salary costs for total nurse staff across all LTC facilities in the study sample. More specifically, Total annual salary costs for all LTC facilities = $\Sigma^{14,668}{}_{i=1}$ Annual salary costs for total nurse staff$_i$.

[177] Appropriate accounting of costs depends on consistency with the benefits to which they are compared. The overall change in staffing cost (increasing nursing staff cost, net of housekeeping, food service and activities-staff costs—which are potentially decreasing) would appropriately be compared with a benefits estimate that also reflects *net* staffing changes; a quantitative approach to such benefits might extrapolate from reduced-form estimates of the effects on patients of other jurisdictions' nursing staffing requirements. By contrast, if benefits assessment reflects an explicit or implicit assumption that new nursing staff spend all their time on nursing activities—not newly covering any of the duties that would have been performed by lost housekeeping, food service or activities staff—then costs from a society-wide perspective are approximated by the (gross) new nursing staffing costs. In other words, in the latter case, a focus only on payroll effects would omit the harms to consumer satisfaction and conditions for remaining staff due to reductions in housekeeping, food service and activities.

TABLE 20—ANNUAL COST FOR THE COMPREHENSIVE MINIMUM NURSE STAFFING REQUIREMENT

Year	Collection of information costs for 24/7 RN (§ 483.35 nursing services)	Collection of information costs for facility assessment (§ 483.71 facility assessment)	24/7 RN requirement (urban facilities)	24/7 RN requirement (rural facilities)	0.55 RN and 2.45 NA HPRD requirement (urban facilities)	0.55 RN and 2.45 NA HPRD requirement (rural facilities)	Total cost
1	$7,461,504.00	$24,176,448.00	$0.00	$0.00	$0	$0	$31,637,952
2	7,633,864.74	24,734,923.95	213,764,107.41	0.00	0	0	246,132,896
3	7,810,207.02	25,306,300.69	218,702,058.29	146,603,030.04	3,662,915,945	0	4,061,337,541
4	7,990,622.80	25,890,876.24	223,754,075.83	149,989,560.03	3,747,529,303	0	4,155,154,438
5	8,175,206.19	26,488,955.48	228,922,794.98	153,454,318.87	3,834,097,230	803,377,179	5,054,515,685
6	8,364,053.45	27,100,850.35	234,210,911.55	156,999,113.64	3,922,664,876	821,935,192	5,171,274,997
7	8,557,263.08	27,726,879.99	239,621,183.61	160,625,793.16	4,013,278,435	840,921,895	5,290,731,450
8	8,754,935.86	28,367,370.92	245,156,432.95	164,336,248.98	4,105,985,167	860,347,191	5,412,947,346
9	8,957,174.88	29,022,657.19	250,819,546.55	168,132,416.34	4,200,833,424	880,221,211	5,537,986,430
10	9,164,085.62	29,693,080.57	256,613,478.07	172,016,275.15	4,297,872,676	900,554,321	5,665,913,916
10 Year Total Cost	82,868,918	268,508,343	2,111,564,589	1,272,156,756	31,785,177,057	5,107,356,989	40,627,632,652

This proposed rule does not include any provisions requiring Medicare, Medicaid or other non-Medicare/Medicaid payors to increase payment rates to providers to meet any or all the expected costs of the proposed requirements. Below, however, we provide estimates of how much of this estimated cost would be due to residents whose care is covered by three payor groups: Medicaid, Medicare, and other non-Medicare/Medicaid payors.

Table 21 provides annual estimates and a 10-year total estimate for the share of facilities' increased staffing costs that would be due to residents utilizing Medicaid. These estimates excluded all collection of information costs. Over a 10-year period, the average annual cost for facilities' due to residents whose stay is paid for by Medicaid would be approximately $2.69 billion. If Medicaid were to fully cover these costs (although there is no expectation that it will), then States would pay $1.1 billion and the Federal government would pay $1.57 billion.

To build these estimates, we used a scenario where facilities' increased cost to meet the new minimum staffing and 24/7 RN requirement for residents utilizing Medicaid was equal to share of residents in the facility using Medicaid. More formally, we first calculated each facility's increased cost for these residents using the following formula: Increased Facility Cost for Medicaid Residents = (minimum staffing requirement cost + 24/7 RN staffing requirement cost) × (% facility residents covered by Medicaid). We then summed all facilities' share of increased costs that was due to residents utilizing Medicaid to the obtain a total estimated cost of $26.9 billion over 10 years.

To provide further details about the facilities' share of the total minimum staffing and 24/7 RN requirements' cost that is due to resident utilizing Medicaid, we broke down the Medicaid costs into how the costs would typically be divided between the Federal and State Medicaid programs. For these estimates, we assumed that the Federal Medicaid share would be equal to the State's FMAP (Federal Medical Assistance Percentage), while each State's share would be equal to the remaining amount (1–FMAP). Using this strategy, we estimated that States' portion of the Medicaid cost would be approximately $11.1 billion over 10 years, while the Federal government's portion of the Medicaid cost would be $15.7 billion.

Table 22 provides annual estimates and a 10-year estimate for the share of facilities' increased labor costs that would be due to residents whose care was covered by Medicare and other non-Medicare/Medicaid payors. These estimates continue to exclude all collection of information costs. Over a 10-year period, facilities' annual cost to meet the proposed requirements would be approximately $454 million for residents utilizing Medicare and $886 million for residents utilizing other non-Medicare/Medicaid payors.

To obtain these estimates, we used a scenario where the cost facilities would incur to meet the new minimum staffing and 24/7 RN requirements for residents utilizing Medicare and other non-Medicare/Medicaid payors would be equal to the share of residents covered by Medicare and non-Medicare/Medicaid payors in each facility.

To obtain the total cost due to residents utilizing Medicare, we first calculated each facility's increased staffing cost for residents utilizing Medicare using the following formula: Increased Facility Cost for Medicare Residents = (minimum staffing requirement cost + 24/7 RN staffing requirement cost) × (% facility residents covered by Medicare). We then summed all facilities' increased costs that was due to residents utilizing Medicare to the obtain a total estimated cost for Medicare of $4.54 billion over 10 years. To obtain the total cost due to residents utilizing other non-Medicare/Medicaid payors, we first calculated each facility's increased cost for residents using a non-Medicare/Medicaid payor using the following formula: Increased Facility Cost for Non-Medicare/Medicaid Payors = (minimum staffing requirement cost + 24/7 RN staffing requirement cost) × (% facility residents covered by non-Medicare/Medicaid Payors). We then summed all facilities' increased costs that were due to residents utilizing other Non-Medicare/Medicaid payors to obtain a total estimated cost of $8.86 billion over 10 years.

TABLE 21: Cost of Comprehensive Minimum Nurse Staffing Requirement Due to Residents Whose Stay is Covered by Medicaid

Year	24/7 RN State Medicaid Cost (Rural Facilities)	24/7 RN Federal Medicaid Cost (Rural Facilities)	24/7 RN State Medicaid Cost (Urban Facilities)	24/7 RN Federal Medicaid Cost (Urban Facilities)	0.55 RN and 2.45 NA HPRD State Medicaid Cost (Rural Facilities)	0.55 RN and 2.45 NA HPRD Federal Medicaid Cost (Rural Facilities)	0.55 RN and 2.45 NA HPRD State Medicaid Cost (Urban Facilities)	0.55 RN and 2.45 NA HPRD Federal Medicaid Cost (Urban Facilities)	Total State Medicaid Cost	Total Federal Medicaid Cost
1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
2	$0	$0	$54,253,616	$83,512,408	$0	$0	$0	$0	$54,253,616	$83,512,408
3	$36,575,549	$62,192,075	$55,506,875	$85,441,545	$0	$0	$1,034,037,099	$1,407,719,404	$1,126,119,523	$1,555,353,025
4	$37,420,445	$63,628,712	$56,789,084	$87,415,245	$0	$0	$1,057,923,356	$1,440,237,723	$1,152,132,884	$1,591,281,679
5	$38,284,857	$65,098,535	$58,100,912	$89,434,537	$206,219,500	$339,553,949	$1,082,361,385	$1,473,507,214	$1,384,966,654	$1,967,594,235
6	$39,169,237	$66,602,312	$59,443,043	$91,500,475	$210,983,171	$347,397,645	$1,107,363,933	$1,507,545,231	$1,416,959,384	$2,013,045,662
7	$40,074,046	$68,140,825	$60,816,177	$93,614,136	$215,856,882	$355,422,530	$1,132,944,040	$1,542,369,525	$1,449,691,146	$2,059,547,017
8	$40,999,757	$69,714,878	$62,221,031	$95,776,622	$220,843,176	$363,632,791	$1,159,115,048	$1,577,998,261	$1,483,179,011	$2,107,122,553
9	$41,946,851	$71,325,292	$63,658,336	$97,989,062	$225,944,653	$372,032,708	$1,185,890,605	$1,614,450,021	$1,517,440,446	$2,155,797,084
10	$42,915,824	$72,972,906	$65,128,844	$100,252,610	$231,163,975	$380,626,664	$1,213,284,678	$1,651,743,817	$1,552,493,321	$2,205,595,996
10 Year Total Cost	$317,386,566	$539,675,535	$535,917,918	$824,936,640	$1,311,011,357	$2,158,666,287	$8,972,920,145	$12,215,571,196	$11,137,235,986	$15,738,849,658

TABLE 22: Cost of Comprehensive Minimum Nurse Staffing Requirement due to Residents whose Stay is Covered by Medicare and Other non-Medicare/Medicaid Payors

Year	24/7 RN Medicare Cost (Rural Facilities)	24/7 RN Medicare Costs (Urban Facilities)	0.55 RN and 2.45 NA HPRD Medicare Cost (Rural Facilities)	0.55 RN and 2.45 NA HPRD Medicare Cost (Urban Facilities)	24/7 RN Other Non-Medicare/Medicaid Payors Cost (Rural Facilities)	24/7 RN Other Non-Medicare/Medicaid Payors Costs (Urban Facilities)	0.55 RN and 2.45 NA HPRD Other Non-Medicare/Medicaid Payors Cost (Rural Facilities)	0.55 RN and 2.45 NA HPRD Other Non-Medicare/Medicaid Payors Cost (Urban Facilities)	Total Cost Due to Residents whose Stay is Covered by Medicare	Total Cost Due to Residents whose Stay is Covered by Other non-Medicare/Medicaid Payors'
1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
2	$0	$26,252,999	$0	$0	$0	$49,745,083	$0	$0	$26,252,999	$49,745,083
3	$12,665,283	$26,859,443	$0	$417,268,633	$35,170,123	$50,894,195	$0	$803,890,809	$456,793,359	$889,955,126
4	$12,957,851	$27,479,897	$0	$426,907,539	$35,982,552	$52,069,851	$0	$822,460,686	$467,345,286	$910,513,089
5	$13,257,177	$28,114,682	$87,130,889	$436,769,103	$36,813,749	$53,272,664	$170,472,841	$841,459,528	$565,271,851	$1,102,018,783
6	$13,563,418	$28,764,131	$89,143,613	$446,858,469	$37,664,147	$54,503,263	$174,410,764	$860,897,243	$578,329,631	$1,127,475,417
7	$13,876,733	$29,428,583	$91,202,830	$457,180,900	$38,534,189	$55,762,288	$178,439,653	$880,783,970	$591,689,045	$1,153,520,099
8	$14,197,285	$30,108,383	$93,309,615	$467,741,778	$39,424,329	$57,050,397	$182,561,609	$901,130,079	$605,357,062	$1,180,166,413
9	$14,525,243	$30,803,887	$95,465,067	$478,546,614	$40,335,031	$58,368,261	$186,778,782	$921,946,184	$619,340,811	$1,207,428,258
10	$14,860,776	$31,515,456	$97,670,311	$489,601,040	$41,266,770	$59,716,568	$191,093,372	$943,243,141	$633,647,583	$1,235,319,850
Total 10 Year Cost	$109,903,766	$259,327,462	$553,922,325	$3,620,874,076	$305,190,890	$491,382,570	$1,083,757,020	$6,975,811,640	$4,544,027,628	$8,856,142,119

As previously stated, this rule does not include any provisions requiring Medicare to increase payment rates to providers to meet any or all the expected costs of the proposed requirements. With specific regards to

the SNF PPS, we do not believe this rule will have meaningful impacts on SNF PPS payment rates. Under section 1888(e)(4) of the Act, the SNF PPS uses per diem Federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. The SNF market basket is used to compute the market basket percentage increase that is used to update the SNF Federal rates on an annual basis, as required by section 1888(e)(4)(ii)(IV) of the Act. While this rule may have minimal impacts on the calculation of the SNF market basket percentage, which could impact annual updates to the SNF PPS rates, we believe that these impacts would be limited.

Additionally, under section 1888(e)(4)(G)(i) of the Act, the Federal rate also incorporates an adjustment to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. While we understand that increased staffing will have an impact on facility costs, we do not believe that these additional costs fall within the scope of relative resource utilization of different patient types. Since this rule impacts the facility as a whole, rather than individual patient types, we do not believe that the rule would impact adjustments made under the SNF PPS to account for facility case-mix.

Finally, section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. As noted most recently in the FY 2024 SNF PPS final rule (88 FR 53211), we continue to use this practice in FY 2024. Given that the wage index used under the SNF PPS is based on analysis of hospital wages and staffing hours and because this rule will impact only on SNF wages and staffing hours, we do not anticipate that the impacts of this rule will be reflected in the SNF PPS wage index. We understand that, as discussed in the FY 2024 SNF PPS final rule (88 FR 53212), there have been comments encouraging CMS to develop a wage index adjustment under the SNF PPS that uses SNF wages and staffing hours as the basis for calculating the adjustment. However, as we state in that rule,

> We note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554, enacted December 21, 2000) gave the Secretary the discretion to establish a geographic reclassification procedure specific to SNFs, but only after collecting the data necessary to establish a SNF PPS wage index that is based on wage data from nursing homes. To date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of the data. More specifically, auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. Adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors (MACs), potentially far in excess of those required under the IPPS, given that there are nearly five times as many SNFs as there are inpatient hospitals. While we continue to believe that the development of such an audit process could improve SNF cost reports, which is determined to be adequately accurate for cost development purposes, in such a manner as to permit us to establish a SNF-specific wage index, we do not believe this undertaking is feasible. (88 FR 53212).

We solicit comment on these assumptions regarding the impact of this rule on the rates paid under the SNF PPS.

Sources of uncertainty about the cost estimate for the 24/7 RN and 0.55 RN and 2.45 NA HPRD requirement include:

The cost estimate assumed that LTC facilities needing RNs and/or NAs to meet these requirements will hire them without laying off other direct care or support staff. Some research,[178] [179] however, has found that when States implemented minimum hour per day requirements for direct care staff (RNs, LPNs, and NAs), LTC facilities responded by reducing indirect care staff, such as housekeeping, food service, and activities staff. If LTC facilities responded to the 24/7 RN and 0.55 and 2.45 NA requirement in similar ways, then a facility's total cost for the requirements could decline significantly relative to what was presented above (see earlier discussion about appropriate accounting of costs depending on consistency between benefit and cost analytic approaches).

The cost estimate assumed that real wages for RNs and NAs would grow at an annual rate of 2.31 percent due to increasing demand for these direct care staff. Differences in demand for RNs and NAs across geographical areas, however, could lead to wages in different areas to increase at different rates, altering the cost for LTC facilities.

The 24/7 cost estimate assumed that RNs would make the average hourly rate for RNs in the facility. If, however, LTC facilities needed to hire RNs to work overnight shifts, which typically command a higher hourly rate, the costs for LTC facilities to meet this requirement could increase.

The cost estimate assumed that no LTC facilities would obtain exemptions from the 0.55 RN and 2.45 NA HPRD requirements, although some facilities could obtain an exemption. Our analysis suggests that using the criteria of being located in an area with a medium staffing shortage, which is defined as the area having an RN and/or NA to population ratio that is 20 percent below the national average, or being located 20-miles from the nearest LTC facility, up to 24 percent of LTC facilities would meet the initial criteria for an exemption from the 2.45 NA HPRD requirement while 28 percent would be eligible for an exemption from the 0.55 RN HPRD requirement. Depending on the number of facilities that obtained an exemption and their expected cost to meet the HPRD requirement, the total cost of the rule for LTC facilities could decline significantly.

In addition to uncertainty about the magnitude of costs, there is uncertainty about whether LTC facilities or other entities in society would bear the cost of meeting the minimum staffing and 24/7 RN requirements. Payors might increase payment rates to meet some or all the rule's cost, which could reduce the cost for LTC facilities relative to what is estimated above.

We welcome any comments regarding the methodology that resulted in an estimated cost of approximately $40.63 billion over a 10-year period for the Comprehensive Minimum Nurse Staffing Requirement and on the potential State and Federal Medicaid impact, as well as the potential impact

[178] Thomas, Kali S., Kathryn Hyer, Ross Andel, and Robert Weech-Maldonado. The Unintended Consequences of Staffing Mandates in Florida Nursing Homes: Impacts on Indirect-Care Staff, 2010, Medicare Care Research and Review, Volume 67, Issue 5, Page 555–573.

[179] Bowblis, John R., and Kathryn Hyer. Nursing Home Staffing Requirements and Input Substitution: Effects on Housekeeping, Food Service, and Activities Staff, 2013, Health Services Reseach, Volume 48, Issue 4, Pages: 1539–1550.

on Medicare and other non-Medicare/Medicaid payors. We are also soliciting comments on all the assumptions we used in our estimate, especially how the available supply of RNs and NAs in different areas nationwide may influence the proposed rule's cost for LTC facilities and other health care providers competing for the same supply of RNs and NAs. Finally, we are seeking comments on how LTC chain ownership may lead to a shifting of employees across facilities from those facilities that are exceeding the proposed minimum staffing requirements to those that are below it.

(4) Impact of 0.55 RN and 2.45 NA HPRD Requirement on States

To provide a more in-depth understanding of the financial and staffing effects of the 0.55 RN HPRD and 2.45 NA HPRD proposed minimum requirement, we examined its impact for different groups of LTC facilities in each State, as well as Washington, DC and Puerto Rico. We first assessed how many full-time employees LTC facilities would need to hire to meet the proposed requirement. In this analysis, we defined a full-time employee as an employee who worked 1,950 hours per year. This definition was based on a full-time employee working 5 days per week, 8 hours per day, with a 30-minute break (37.5 hours/week × 52 weeks/year). We continued to assume that no facilities would obtain exemptions from the minimum staffing requirement. We also continued to subtract any cost that facilities incur or employees they would need to hire to meet the 24/7 RN requirements up to 0.55 RN HPRD. All calculations used the October 2021 *Care Compare* data set that provided each LTC facility's average daily resident census and HPRD for RNs, LPNs/LVNs and NAs using the PBJ System data from 2021 Q2.

For each facility, we first calculated the total number of full-time RNs, LPN/LVNs, and NAs working in a facility using the following formula: (facility specific care type HPRD × Average daily resident census × 365)/1,950. For example, if a facility has 10 residents and provides an average of 0.1 RN HPRD, then during the year, it will provide a total of 365 hours of RN care (0.1 RN HPRD × 10 residents × 365 days) yearly and have 0.187 full-time RNs. We then calculated the number of additional RNs needed by subtracting the current average hours per resident day for RNs from the minimum required hours per resident day. Continuing with our example in this section, the LTC facility would need to provide 1,642.5 additional RN hours per year ([0.55 RN HPRD − 0.1 HPRD] × 10 residents × 365 days = 1642.5 hours) and hire 0.84 additional full-time RNs.

To calculate the total number of additional NAs needed we subtracted the current average hours per resident day for NAs from the minimum required hours per resident day. For example, if the same facility as previously mentioned with 10 residents provided an average of 2.2 NA HPRD, then to meet the 2.45 HPRD requirement it would need to provide 912.5 additional NA hours per year ([2.45 NA HPRD − 2.2 NA HPRD] × 10 residents × 365 days = 912.5 hours) and hire 0.47 (912.5 hours needed/1,950 hours yearly per full-time employee) full-time NAs.

Table 23 shows the total number of RNs and NAs employed by LTC facilities in each State's urban areas, the number of full-time RNs and NAs that LTC facilities would need to hire, and the percent increase in RNs and NAs that LTC facilities in each State would need to meet the proposed minimum staffing standard. Table 24 provides the same information for LTC facilities located in each State's rural areas.

Louisiana would need the largest increase in RNs in percentage terms. The number of full-time RNs in urban LTC facilities would need to increase by nearly 96 percent, while rural LTCs would need to increase the number of RNs by more than 73 percent to meet minimum standard. Facilities in Texas would need to hire the most overall RNs with the State needing 1,615 additional full-time RNs in urban areas and more than 311 RNs in rural areas. Across the United States, however, the number of RNs that facilities would need to hire varies widely, with several States, including Delaware and Hawaii, not needing to hire any RNs to meet the requirement.

Illinois would need the largest percentage increase for NAs in urban areas. The State would need to add nearly 6,000 full-time NAs and increase the overall number of NAs working in LTC facilities by more than 42 percent. Similar to RNs, however, there would be wide variation in the percentage increase in NAs across States. Florida, for example, would need to increase the size of its NA labor force in LTC facilities by less than 2 percent to meet the requirement.

TABLE 23—CURRENT AND ADDITIONAL FULL-TIME RNS AND NAS NEEDED PER STATE TO MEET 0.55 RN AND 2.45 NA HPRD STAFFING REQUIREMENT FOR URBAN LTC FACILITIES

State	Existing full-time RNs	Additional RNs needed	Percent increase in RNs needed	Existing full-time NAs	Additional NAs needed	Percent increase in NAs needed
Alabama	1,416	129	9.1	5,011	922	18.4
Alaska	108	0	0	216	3	1.2
Arizona	1,247	101	8.1	4,036	651	16.1
Arkansas	559	220	39.3	3,775	199	5.3
California	9,461	1,390	14.7	40,659	1,734	4.3
Colorado	2,026	9	0.5	4,687	718	15.3
Connecticut	2,145	122	5.7	6,735	1,136	16.9
Delaware	648	0	0	1,376	259	18.8
District of Columbia	468	0	0	923	45	4.9
Florida	8,208	390	4.8	29,310	414	1.4
Georgia	1,469	443	30.1	6,446	1,996	31
Hawaii	743	0	0	1,289	28	2.2
Idaho	437	1	0.2	1,176	105	8.9
Illinois	5,965	551	9.2	13,944	5,985	42.9
Indiana	2,611	261	10	8,917	2,087	23.4
Iowa	1,254	28	2.2	4,010	367	9.2
Kansas	1,054	51	4.8	3,652	369	10.1
Kentucky	1,249	100	8	3,997	787	19.7
Louisiana	762	730	95.9	6,306	1,225	19.4
Maine	576	3	0.5	1,499	36	2.4
Maryland	2,939	47	1.6	7,572	1,588	21
Massachusetts	3,973	191	4.8	12,156	2,184	18
Michigan	3,050	235	7.7	8,862	2,268	25.6

TABLE 23—CURRENT AND ADDITIONAL FULL-TIME RNS AND NAS NEEDED PER STATE TO MEET 0.55 RN AND 2.45 NA HPRD STAFFING REQUIREMENT FOR URBAN LTC FACILITIES—Continued

State	Existing full-time RNs	Additional RNs needed	Percent increase in RNs needed	Existing full-time NAs	Additional NAs needed	Percent increase in NAs needed
Minnesota	2,968	3	0.1	6,267	573	9.1
Mississippi	509	68	13.3	1,955	319	16.3
Missouri	1,707	442	25.9	7,786	1,504	19.3
Montana	163	4	2.2	487	88	18.1
Nebraska	743	17	2.3	2,313	139	6
Nevada	667	45	6.7	1,796	328	18.3
New Hampshire	388	13	3.4	1,256	168	13.3
New Jersey	4,756	335	7	13,412	2,856	21.3
New Mexico	324	27	8.2	1,184	194	16.4
New York	10,277	745	7.2	32,047	5,904	18.4
North Carolina	2,381	376	15.8	9,175	1,774	19.3
North Dakota	313	1	0.4	1,176	12	1
Ohio	5,169	521	10.1	16,844	4,552	27
Oklahoma	568	203	35.7	3,725	333	8.9
Oregon	762	17	2.3	3,170	14	0.4
Pennsylvania	7,575	242	3.2	20,086	4,917	24.5
Puerto Rico	29	0	0	0	26	.....
Rhode Island	947	14	1.5	2,752	284	10.3
South Carolina	1,325	163	12.3	4,793	794	16.6
South Dakota	240	0	0	618	88	14.2
Tennessee	1,693	230	13.6	6,047	1,495	24.7
Texas	4,451	1,615	36.3	21,663	6,101	28.2
Utah	926	2	0.2	2,012	197	9.8
Vermont	72	4	5	239	24	10.1
Virginia	1,951	344	17.6	6,838	2,148	31.4
Washington	1,967	22	1.1	5,257	311	5.9
West Virginia	682	22	3.2	1,987	431	21.7
Wisconsin	2,214	16	0.7	5,220	619	11.9
Wyoming	85	3	3.4	212	51	23.9
United States	108,220	10,495	9.7	356,871	61,348	17.2

TABLE 24—CURRENT AND ADDITIONAL FULL-TIME RNS AND NAS NEEDED PER STATE TO MEET 0.55 RN AND 2.45 NA HPRD STAFFING REQUIREMENT FOR RURAL LTC FACILITIES

State	Existing full-time RNs	Additional RNs needed	% Increase in RNs needed	Existing full-time NAs	Additional NAs needed	% Increase in NAs needed
Alabama	721	69	9.5	2,884	280	9.7
Alaska	108	0	0	256	0	0
Arizona	60	4	6.4	169	60	35.2
Arkansas	487	115	23.6	2,930	159	5.4
California	150	37	24.5	847	32	3.8
Colorado	374	6	1.5	1,080	89	8.3
Connecticut	118	6	4.6	379	68	18.1
Delaware	0	0	.....	0	0	.....
District of Columbia	0	0	.....	0	0	.....
Florida	286	51	17.9	1,501	23	1.5
Georgia	732	177	24.2	3,147	954	30.3
Hawaii	177	0	0	393	33	8.5
Idaho	163	1	0.6	542	21	3.8
Illinois	1,049	85	8.1	3,519	961	27.3
Indiana	1,147	51	4.5	3,510	740	21.1
Iowa	1,458	29	2	4,789	534	11.1
Kansas	862	10	1.1	3,224	130	4
Kentucky	1,212	70	5.8	4,011	543	13.5
Louisiana	262	192	73.4	2,166	284	13.1
Maine	403	0	0	1,151	5	0.4
Maryland	125	0	0	353	44	12.5
Massachusetts	12	0	0	40	0	0
Michigan	1,299	19	1.5	3,624	273	7.5
Minnesota	1,218	1	0.1	3,417	113	3.3
Mississippi	982	70	7.1	3,544	515	14.5
Missouri	823	133	16.2	3,959	639	16.1
Montana	356	5	1.5	996	125	12.6
Nebraska	630	13	2.1	2,380	129	5.4
Nevada	61	0	0	189	23	12.1
New Hampshire	349	8	2.4	1,206	132	10.9
New Jersey	0	0	.....	0	0	.....
New Mexico	256	7	2.5	796	93	11.7
New York	827	37	4.5	2,609	824	31.6
North Carolina	800	92	11.5	2,945	562	19.1
North Dakota	386	6	1.7	1,331	53	4
Ohio	1,681	109	6.5	5,264	1,395	26.5
Oklahoma	437	94	21.4	3,040	196	6.4
Oregon	158	2	1.1	528	0	0
Pennsylvania	1,026	50	4.9	3,152	757	24

TABLE 24—CURRENT AND ADDITIONAL FULL-TIME RNS AND NAS NEEDED PER STATE TO MEET 0.55 RN AND 2.45 NA HPRD STAFFING REQUIREMENT FOR RURAL LTC FACILITIES—Continued

State	Existing full-time RNs	Additional RNs needed	% Increase in RNs needed	Existing full-time NAs	Additional NAs needed	% Increase in NAs needed
Puerto Rico	0	0	.....	0	0	.....
Rhode Island	0	0	.....	0	0	.....
South Carolina	279	62	22.4	1,121	250	22.3
South Dakota	488	2	0.5	1,382	146	10.6
Tennessee	683	78	11.4	2,515	603	24
Texas	1,138	311	27.3	6,143	1,763	28.7
Utah	122	0	0	269	30	11.3
Vermont	250	2	0.8	734	90	12.3
Virginia	574	99	17.3	1,990	651	32.7
Washington	193	5	2.5	535	84	15.6
West Virginia	399	32	8	1,464	223	15.2
Wisconsin	1,142	4	0.3	2,835	335	11.8
Wyoming	245	0	0	626	64	10.2
United States	26,708	2,144	8.0	95,485	15,028	15.7

We then assessed the financial cost for facilities to implement the proposed 0.55 RN and 2.45 NA HPRD minimum staffing requirement. To estimate the yearly cost per State, we used the formulas described in section VI.C.1.(a) to first estimate each facility's yearly cost to meet the requirement. We also assumed that LTC facilities exceeding the minimum requirements for either RNs and/or NAs would not reduce staff to the minimum required level or lay off other staff to reduce costs. We then calculated the average cost per resident day by summing the total cost of meeting the requirement for all facilities in the State and dividing it by the total number of resident days for all facilities needing additional RNs or NAs. We estimated the average cost per resident day only for facilities needing staff to provide a more complete picture of the burden that the rule would impose on these facilities.

Table 25 provides the yearly Statewide cost to implement the requirement, as well as the average cost per resident day for facilities in rural and urban areas that will need to hire staff to meet the requirement. Facilities in Illinois that were not meeting the minimum staffing standard would need to spend the most with an average cost of $20.41 per resident day. The highest overall cost occurs in New York where facilities would need to collectively spend nearly $409 million to meet the minimum staffing requirement. The cost also varied across urban and rural areas. In Illinois, LTC facilities in urban areas that need staff would need to spend an average of $21.70 per resident day to meet the requirement, while in Florida, they would need to spend less than $5.25 per resident day. Virginia had the highest average cost for rural LTC facilities at $17.63 per resident day.

TABLE 25—LTC FACILITIES IN EACH STATE NEEDING RNS AND/OR NAS AND AVERAGE COST PER RESIDENT DAY BY RURAL AND URBAN LOCATION

State	Yearly state-wide cost ($ million)	Average cost per resident day (statewide)	Urban LTC facilities needing RNs and/or NAs	Average cost per resident day (urban areas)	Rural LTC facilities needing RNs and/or NAs	Average cost per resident day (rural areas)
Alabama	57.5	$10.03	120	$10.59	57	$8.76
Alaska	0.1	7.50	1	7.50	0	0.00
Arizona	35.8	12.07	99	12.06	8	12.17
Arkansas	33.9	7.40	103	7.96	80	6.58
California	222.7	9.55	725	9.57	26	8.48
Colorado	37.4	10.18	122	10.29	26	9.37
Connecticut	63.4	12.04	140	12.25	12	9.14
Delaware	12.0	11.18	36	11.18	0	0.00
District of Columbia	1.9	6.33	7	6.33	0	0.00
Florida	54.3	5.32	271	5.23	22	6.46
Georgia	154.1	16.26	201	17.05	125	14.69
Hawaii	2.6	9.41	5	7.97	3	10.84
Idaho	5.3	6.95	29	7.38	11	5.32
Illinois	353.5	20.41	412	21.70	155	14.49
Indiana	150.1	13.95	307	14.66	151	12.06
Iowa	40.8	8.94	97	9.16	174	8.78
Kansas	24.9	8.79	90	10.23	63	5.86
Kentucky	67.5	11.11	111	13.21	109	8.72
Louisiana	117.9	15.57	175	16.71	70	12.10
Maine	2.4	5.89	12	7.17	4	2.02
Maryland	77.5	12.00	168	12.14	10	8.64
Massachusetts	125.4	12.58	306	12.58	0	0.00
Michigan	128.6	14.78	250	15.77	68	9.49
Minnesota	33.6	10.09	109	10.81	49	7.58
Mississippi	38.3	9.46	54	10.89	103	8.62
Missouri	117.3	12.75	233	14.21	147	9.61
Montana	10.4	13.81	13	14.08	27	13.61
Nebraska	13.0	8.54	26	9.77	58	7.61
Nevada	18.3	13.90	34	13.80	4	15.92
New Hampshire	18.4	13.58	27	12.88	19	14.60
New Jersey	163.2	14.74	285	14.74	0	0.00
New Mexico	15.3	10.87	29	11.33	22	9.87

TABLE 25—LTC FACILITIES IN EACH STATE NEEDING RNS AND/OR NAS AND AVERAGE COST PER RESIDENT DAY BY RURAL AND URBAN LOCATION—Continued

State	Yearly statewide cost ($ million)	Average cost per resident day (statewide)	Urban LTC facilities needing RNs and/or NAs	Average cost per resident day (urban areas)	Rural LTC facilities needing RNs and/or NAs	Average cost per resident day (rural areas)
New York	408.9	14.66	430	14.56	72	15.63
North Carolina	126.9	13.01	256	13.33	87	11.99
North Dakota	3.9	10.81	5	7.81	15	11.84
Ohio	287.6	14.68	577	15.19	227	13.06
Oklahoma	40.6	9.15	108	10.62	96	7.03
Oregon	2.8	4.91	26	4.75	1	8.28
Pennsylvania	297.8	14.96	470	15.19	101	13.56
Puerto Rico	0.0	0.00	3	0.00	0	0.00
Rhode Island	16.1	9.87	53	9.87	0	0.00
South Carolina	59.4	12.63	113	12.40	35	13.39
South Dakota	10.4	9.53	21	9.84	43	9.34
Tennessee	101.8	13.10	181	13.68	100	11.77
Texas	408.0	15.35	773	15.93	305	13.36
Utah	7.5	6.40	49	6.38	8	6.52
Vermont	6.3	10.75	4	12.28	16	10.28
Virginia	156.1	19.18	180	19.65	63	17.63
Washington	23.4	10.27	78	9.40	15	15.54
West Virginia	30.1	10.88	59	11.00	44	10.68
Wisconsin	40.9	11.15	114	11.79	75	10.06
Wyoming	6.2	13.03	6	14.37	13	11.97
United States	4,232.6	13.24	7,613	13.69	2,685	11.43

Table 26 shows the average cost per resident day for facilities in each State that need additional staff, dividing facilities based on their size into three groups: less than 50 beds, 50 to 100 beds, and more than 100 beds. Within each group of LTC facilities, the cost varied widely by the number of beds and State. In Oklahoma, the average cost per resident day for facilities that have fewer than 50 beds and need additional RNs or NAs would be $1.84, while in Illinois, the average cost per resident day for facilities with more than 100 beds would be $22.10.

TABLE 26—NUMBER OF LTC FACILITIES IN EACH STATE NEEDED TO HIRE RNS AND/OR NAS AND AVERAGE COST PER RESIDENT DAY BY FACILITY SIZE

State	LTC facilities needing RNs and/or NA	Statewide hiring cost ($ million)	Average cost per resident day (statewide)	Cost—<50 beds	Cost—50 to 100 beds	Cost—>100 beds
Alabama	177	57.5	10.03	$5.60	$8.61	$10.51
Alaska	1	0.1	7.50	.....	7.50	.....
Arizona	107	35.8	12.07	11.89	7.44	13.24
Arkansas	183	33.9	7.40	.....	7.39	7.40
California	751	222.7	9.55	5.33	9.16	10.06
Colorado	148	37.4	10.18	10.94	9.33	10.65
Connecticut	152	63.4	12.04	19.07	10.35	12.34
Delaware	36	12.0	11.18	7.15	7.38	11.94
District of Columbia	7	1.9	6.33	3.88	18.10	4.45
Florida	293	54.3	5.32	7.69	5.67	5.24
Georgia	326	154.1	16.26	10.12	14.71	17.21
Hawaii	8	2.6	9.41	3.82	14.83	8.42
Idaho	40	5.3	6.95	5.52	7.80	6.43
Illinois	567	353.5	20.41	8.51	14.51	22.10
Indiana	458	150.1	13.95	14.24	12.79	14.77
Iowa	271	40.8	8.94	8.82	8.71	9.73
Kansas	153	24.9	8.79	8.05	8.08	10.69
Kentucky	220	67.5	11.11	9.16	11.17	11.13
Louisiana	245	117.9	15.57	4.91	10.11	16.50
Maine	16	2.4	5.89	.....	6.38	4.78
Maryland	178	77.5	12.00	6.36	9.83	12.44
Massachusetts	306	125.4	12.58	11.71	11.40	12.83
Michigan	318	128.6	14.78	12.36	12.49	15.97
Minnesota	158	33.6	10.09	10.30	10.13	9.96
Mississippi	157	38.3	9.46	12.76	7.93	10.45
Missouri	380	117.3	12.75	6.62	9.44	14.63
Montana	40	10.4	13.81	16.03	16.75	10.77
Nebraska	84	13.0	8.54	8.13	7.37	10.67
Nevada	38	18.3	13.90	6.79	9.47	15.14
New Hampshire	46	18.4	13.58	4.31	13.58	13.86
New Jersey	285	163.2	14.74	10.34	11.22	15.00
New Mexico	51	15.3	10.87	10.24	10.86	10.90
New York	502	408.9	14.66	9.47	17.38	14.48
North Carolina	343	126.9	13.01	11.27	11.71	13.77
North Dakota	20	3.9	10.81	9.93	5.47	15.42
Ohio	804	287.6	14.68	11.28	13.76	16.15
Oklahoma	204	40.6	9.15	1.84	5.51	11.08

TABLE 26—NUMBER OF LTC FACILITIES IN EACH STATE NEEDED TO HIRE RNS AND/OR NAS AND AVERAGE COST PER RESIDENT DAY BY FACILITY SIZE—Continued

State	LTC facilities needing RNs and/or NA	Statewide hiring cost ($ million)	Average cost per resident day (statewide)	Cost—<50 beds	Cost—50 to 100 beds	Cost—>100 beds
Oregon	27	2.8	4.91	8.60	3.79	5.94
Pennsylvania	571	297.8	14.96	12.90	12.73	15.45
Puerto Rico	3	.....	.....	.....	.....	.....
Rhode Island	53	16.1	9.87	9.19	9.16	10.21
South Carolina	148	59.4	12.63	8.79	12.48	12.82
South Dakota	64	10.4	9.53	9.14	9.37	10.87
Tennessee	281	101.8	13.10	7.40	11.86	13.66
Texas	1,078	408.0	15.35	10.03	12.69	16.39
Utah	57	7.5	6.40	9.69	6.84	5.62
Vermont	20	6.3	10.75	5.46	15.05	9.59
Virginia	243	156.1	19.18	5.92	16.13	20.25
Washington	93	23.4	10.27	10.68	8.44	11.48
West Virginia	103	30.1	10.88	9.03	9.86	11.90
Wisconsin	189	40.9	11.15	7.93	10.40	12.47
Wyoming	19	6.2	13.03	.....	8.27	14.84
United States	11,022	4,232.6	13.24	9.25	14.25	11.37

In Table 27, we calculated the average cost by State for facilities needing staff to meet the minimum staffing requirement based on whether the facility accepted patients with Medicare, Medicaid, or both Medicare and Medicaid. The highest per resident day cost would be for a single Medicaid-only facility in North Dakota that would need to spend an average of $31.33 per resident day to meet the staffing requirement. The lowest per resident day cost for facilities needing staff would be for two Medicare-only facilities in West Virginia that would need to spend $0.59 per resident day to meet the requirement.

TABLE 27—NUMBER OF LTC FACILITIES IN STATE NEEDING TO HIRE RNS AND/OR NAS AND AVERAGE COST PER RESIDENT DAY BY MEDICARE, MEDICAID AND DUAL ACCEPTANCE STATUS

State	Medicare only facilities	Medicare only facilities cost per resident day	Medicaid only facilities	Medicaid only facilities cost per resident day	Medicare and Medicaid facilities	Medicare and Medicaid facilities cost per resident day
Alabama	4	$5.87	1	$12.92	171	$10.06
Alaska	0	0.00	0	0.00	1	7.50
Arizona	13	7.84	0	0.00	92	12.54
Arkansas	0	0.00	2	2.18	180	7.50
California	7	3.51	19	26.77	722	9.02
Colorado	9	5.85	3	26.07	135	10.15
Connecticut	0	0.00	0	0.00	151	12.02
Delaware	3	6.47	2	10.37	31	11.36
District of Columbia	0	0.00	0	0.00	7	6.33
Florida	6	9.96	0	0.00	285	5.31
Georgia	4	5.94	0	0.00	322	16.36
Hawaii	0	0.00	0	0.00	8	9.41
Idaho	0	0.00	0	0.00	40	6.95
Illinois	9	5.58	14	37.51	542	20.11
Indiana	7	17.82	5	11.21	444	13.96
Iowa	2	3.09	5	11.49	261	8.93
Kansas	1	12.98	9	20.62	142	8.31
Kentucky	5	9.72	0	0.00	213	11.13
Louisiana	6	4.27	0	0.00	232	15.30
Maine	0	0.00	0	0.00	16	5.89
Maryland	2	10.02	0	0.00	175	12.05
Massachusetts	4	14.14	0	0.00	296	12.58
Michigan	1	6.28	1	2.71	314	14.72
Minnesota	4	5.84	6	27.71	146	9.19
Mississippi	3	19.62	12	9.42	142	9.41
Missouri	5	9.63	6	15.99	368	12.74
Montana	0	0.00	0	0.00	40	13.81
Nebraska	0	0.00	3	7.04	77	8.59
Nevada	3	6.74	1	24.55	34	13.70
New Hampshire	0	0.00	1	6.60	45	13.78
New Jersey	5	8.83	0	0.00	278	14.66
New Mexico	0	0.00	1	8.08	50	10.89
New York	0	0.00	0	0.00	500	14.69
North Carolina	7	11.76	1	11.94	332	13.05
North Dakota	1	31.33	0	0.00	18	10.98
Ohio	5	8.84	0	0.00	792	14.70
Oklahoma	2	6.39	2	6.86	200	9.20
Oregon	0	0.00	2	7.52	23	4.60
Pennsylvania	33	9.70	1	3.98	535	15.12
Puerto Rico	3	0.00	0	0.00	0	0.00

TABLE 27—NUMBER OF LTC FACILITIES IN STATE NEEDING TO HIRE RNS AND/OR NAS AND AVERAGE COST PER RESIDENT DAY BY MEDICARE, MEDICAID AND DUAL ACCEPTANCE STATUS—Continued

State	Medicare only facilities	Medicare only facilities cost per resident day	Medicaid only facilities	Medicaid only facilities cost per resident day	Medicare and Medicaid facilities	Medicare and Medicaid facilities cost per resident day
Rhode Island	0	0.00	0	0.00	53	9.87
South Carolina	10	6.87	0	0.00	137	12.82
South Dakota	0	0.00	6	5.67	57	9.90
Tennessee	18	9.05	4	8.30	259	13.34
Texas	23	8.53	6	10.40	1,041	15.51
Utah	4	9.15	4	12.85	49	6.00
Vermont	0	0.00	0	0.00	20	10.75
Virginia	9	3.26	5	15.09	227	19.55
Washington	0	0.00	0	0.00	93	10.27
West Virginia	2	0.59	1	8.01	98	10.81
Wisconsin	2	1.40	1	5.13	184	11.24
Wyoming	0	0.00	0	0.00	19	13.03
United States	222	8.39	124	19.33	10,597	13.96

b. Benefits of LTC Minimum Staff Requirement

Literature evidence suggests that higher staffing is associated with better quality of patient care and patient health outcomes.[180] [181] [182] While many of these benefits are difficult to quantify, research suggests a positive correlation between higher RN HPRD and more community discharges, as well as fewer hospitalizations and emergency department visits that result in significant savings for Medicare. The strongest comes from the 2022 Nursing Home Staffing Study that analyzes the Medicare savings that are likely to result from different case-mix adjusted RN hours per resident day (HPRD) requirements.

The study first used the PBJ system, which contains data on daily hours worked by RNs, and data from the Minimum Data Set (MDS) on resident acuity and the number of residents in the facility, to calculate the acuity-adjusted RN HPRD for 14,140 LTC facilities based on data from 2022 Q2.[183] We would note, as discussed above, that while the benefits described in this section were calculated on the basis of acuity-adjusted data, the minimum staffing requirements being proposed in this rule will be applied independent of an individual facility's case-mix. We understand that this may impact the comparability of the benefits described in this section to those which may occur if these requirements are finalized, but we also believe that the acuity adjusted data more accurately reflect that which is publicly reported through Care Compare and the PBJ System. Registered nurses included RNs, RNs with administrative duties, and RN directors of nursing. It then used Nurse Home Compare Data from 2021Q2 to 2022Q1 to examine the impact of different RN staffing levels on five claims-based measures: short-stay hospital readmission, short-stay emergency department (ED) visits, long-stay hospitalizations per 1,000 long-stay resident days, long-stay ED visits per 1,000 long-stay resident days, and the rate of successful return to home or community. More specifically, the study ran a multivariate regression model that used the 1st and 2nd RN staffing decile as the reference group and included the 3rd through the 10th deciles of RN staffing as covariates in the model. The model also includes several additional covariates that take into account LTC facility specific characteristics that include: (1) facility size (number of certified beds), (2) ownership type (for-profit, non-profit or government owned), (3) whether the facility is located in a rural area, (4) the facility's Medicaid population quartile, (5) whether the facility is hospital-based, (6) the facility's status in the Special Focus Facility Program, and (7) whether the facility is part of a continuing care retirement community. They then used the model coefficients to identify the mean outcomes that were associated with each staffing level above the 1st and 2nd RN staffing deciles.

After identifying the mean outcome rate for each of the five measures that was associated with each staffing level, they compared it to the adjusted mean outcome rate for each facility to the rate the facility would have if it met the minimum required RN staffing level. For those facilities above the minimum RN staffing level, they assumed that they would maintain their current RN staffing level. Based on the facility's number of short-stay residents, as well as long-stay resident days, they then estimated the total savings at the facility level. To measure costs savings for Medicare, the used an average estimated cost of $20,400 per hospitalization, $2,500 per ED visit, and for community and home discharge, the reduction in the number of Medicare-covered SNF days multiplied by the average daily payment amount. Using these criteria, the study estimates that a minimum RN requirement of between 0.52 and 0.60 HPRD would result in $318,259,715 in annual Medicare savings.[184]

Given that our proposed RN HPRD level is 0.55 we consider this amount to be our best estimate of the rule's financial benefits. There are also likely to be cost savings for Medicaid due to fewer hospitalizations and emergency department visits, although the 2022

[180] Cai, S., Yan, D., & Intrator, O. (2021). COVID–19 cases and death in nursing homes: The role of racial and ethnic composition of facilities and their communities. Journal of the American Medical Directors Association, 22(7), 1345–1351.

[181] Harris, J.A., Engberg, J., & Castle, N.G. (2020). Organizational and geographic nursing home characteristics associated with increasing prevalence of resident obesity in the United States. *Journal of Applied Gerontology, 39*(9), 991–999. *https://doi.org/10.1177/07* 464819843045 *https://doi.org/10.1177/07* 464819843045 *https://doi.org/10.1177/07* 464819843045 *https://doi.org/10.1177/07* 464819843045.

[182] Min, A., & Hong, H.C. (2019). Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A cross-sectional study using the US Nursing Home Compare database. *Geriatric Nursing, 40*(2), 160–165. *https://doi.org/10.1016/j.ghttps://doi.org/10.1016/j.*gerinurse.2018.09.010*https://doi.org/10.1016/j.ghttps://doi.org/10.1016/j.*gerinurse.2018.09.010.

[183] In the study, Appendix E, Section E.1.1 provides details on the criteria used for the acuity adjustment.

[184] Abt Associates. (2022). Nursing Home Staffing Study Comprehensive report. Page 110. Report prepared for the Centers for Medicare & Medicaid Services. *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.*

Nursing Home Staffing Study did not quantify them. Higher RN and NA staffing levels may also lead to lower employee burnout and turnover, reducing LTC facilities' costs to recruit new staff and lowering dependence on temporary employees, who often command higher hourly rates. Additionally, while the savings estimate above reflects an acuity-adjusted standard, given variability in acuity across facilities, we believe that these savings estimates provide guidance on the potential impact of applying the minimum staffing requirements independent of a facility's case-mix. We invite comments on this assumption and to what extent the benefits described in this section should be calculated using unadjusted data from PBJ and Care Compare.

Table 28 provides the estimated quantifiable benefits annually and over 10 years. Since the 0.55 RN HPRD requirement will not go into effect until Year 3, we estimate no reduction in Emergency Department visits and hospitalizations, as well as increase in discharges to home or the community for the first 2 years. Over 10 years, we estimate a total of approximately $2.55 billion in Medicare cost savings. We are soliciting comments on additional benefits from increased RN and NA staffing and note that the table below does not reflect the unquantifiable benefits of this rule.

TABLE 28—MINIMUM STAFFING REQUIREMENT AND MEDICARE COST SAVINGS

Year	Medicare cost savings
1	$0
2	0
3	318,259,715
4	318,259,715
5	318,259,715
6	318,259,715
7	318,259,715
8	318,259,715
9	318,259,715
10	318,259,715
Total 10 Year Savings	2,546,077,720

Sources of uncertainty about the benefits of the 24/7 RN and 0.55 RN and 2.45 NA HPRD requirement parallel the cost uncertainty discussed earlier but with some differences:

The benefits estimate assumed that LTC facilities needing RNs and/or NAs to meet these requirements will hire the necessary staff. It does not, however, take into account how changes in the number of hours per resident day of other direct care or support staff might affect the impact that increasing the RN HPRD will have on Medicare cost savings. Some research, however, has found that when States implemented minimum hour per day requirements for direct care staff (RNs, LPNs, and NAs), LTC facilities responded by reducing indirect care staff, such as housekeeping, food service, and activities staff. [185] [186] If LTC facilities respond to the newly proposed 24/7 RN and 0.55 and 2.45 NA requirement in similar ways, then benefits of the requirements would be lower than what is presented above (see earlier discussion about appropriate accounting depending on the consistency between benefit and cost analytic approaches).

The benefits estimate assumed that LTC facilities that exceed the 24/7 RN and 0.55 RN and 2.45 NA HPRD requirements would maintain RN and NA staffing at their current levels. Research examining how LTC facilities have responded to State level staffing mandates provides mixed evidence for this assumption, with some research finding no evidence that LTC facilities exceeding minimum requirements reduce staffing, while other research suggests that they do.[187] If LTC facilities reduced RN and NA staffing levels to a level that is closer to the minimum requirement, then benefits would be lower than what is estimated above.

The benefits estimate assumed that no LTC facilities would obtain exemptions from the 0.55 RN and 2.45 NA HPRD requirements, although some facilities could obtain such an exemption. Our analysis suggests that, using the criteria of being located in an area with a medium staffing shortage or being located 20 miles from the nearest LTC facility, up to 24 percent of LTC facilities would meet the initial criteria for an exemption from the 2.45 NA HPRD requirement while 28 percent would be eligible for an exemption from the 0.55 RN HPRD requirement. Depending on the number of facilities that obtain an exemption, the total benefits of the rule could be lower than what is presented above.

States could vary in how they respond to the increased staffing requirement, including whether they pay at least some of the additional nursing staffing costs with Medicaid funds. Benefits consequences are contingent upon such choices. For example, if overall Medicaid spending does not increase, but funds are shifted from other uses to increased LTC facility staffing, there would be negative health benefits for the patients experiencing reduced Medicaid coverage.

c. Transfers Associated With the 24/7 RN and 0.55 RN and 2.45 NA HPRD Minimum Staffing Requirements

We do not estimate transfers associated with the 24/7 RN and 0.55 RN and 2.45 NA HPRD minimum staffing portion of this rule since there are no requirements that Medicare, Medicaid and other non-Medicare/Medicaid payors increase payment rates in response to these requirements. In Tables 21 and 22, however, we do provide a breakdown of how much of the estimated cost from the proposed rule is due to LTC residents whose stay is covered by each payor type

[185] Thomas, Kali S., Kathryn Hyer, Ross Andel, and Robert Weech-Maldonado. The Unintended Consequences of Staffing Mandates in Florida Nursing Homes: Impacts on Indirect-Care Staff, 2010, Medicare Care Research and Review, Volume 67, Issue 5, Pages 555–573.

[186] Bowblis, John R., and Kathryn Hyer. Nursing Home Staffing Requirements and Input Substitution: Effects on Housekeeping, Food Service, and Activities Staff, 2013, Health Services Research, Volume 48, Issue 4, Pages: 1539–1550.

[187] Chen, Min M., and David C. Grabowski. Intended and Unintended Consequences of Minimum Staffing Standards for Nursing Homes, 2015, Volume 24, Pages 822–839.

(Medicare, Medicaid, and other non-Medicare/Medicaid payors).

(5) Medicaid Institutional Payment Transparency Reporting Provision Impacts

Under our authority at sections 1902(a)(6) and (a)(30) of the Act with regard to fee-for-service delivery systems, and sections 1902(a)(4) and 1932(c) of the Act with regard to managed care, we are proposing new reporting requirements at §§ 442.43(b) and 442.43(c) for States to report annually, by facility and by delivery system, on the percent of payments for Medicaid-covered services delivered by nursing facilities and ICF/IIDs that are spent on compensation for direct care workers and support staff.

Under this proposal, States would be required to report annually to us on the percent of payments for nursing facility and ICF/IID services that are spent on compensation for direct care workers and support staff. We are considering additional requirements that States report on median hourly wages for direct care workers and support staff in these facilities, and the State's FFS per diem rates for nursing facility and ICF/IID services. (The estimated costs of these additional proposals have been factored into our overall cost estimates.) We are proposing that States would be required to post all reported data on a State-maintained website, which States would review quarterly to ensure the information remains accurate and up-to-date. We believe that gathering and sharing data about the amount of Medicaid dollars that are going to the compensation of workers is a critical step in the larger effort to understand the ways we can enact policies that support the institutional care workforce and thereby help advance access to high quality care for Medicaid beneficiaries.

a. Costs of Medicaid Institutional Payment Transparency Reporting

As outlined in the Collection of Information (section IV. of this proposed rule), we estimate implementation costs to States of $622,551 to come into compliance with the reporting requirements proposed at §§ 442.43(b) and 442.43(c); we estimate an annual total cost of $97,470 once the reporting requirement went into effect. Additionally, under our proposal at § 442.43(d), States would be required to make this information available on a public website; as outlined in the Collection of Information (section IV. of this proposed rule) we estimate an implementation cost to States of $239,333 and an ongoing annual cost of $295,527 once reporting starts. The total State costs for both the proposed reporting and website requirements are thus estimated at $861,884 for implementation costs ($622,551 + $239,333) and $392,997 ongoing annual costs once the reporting starts ($97,470 + $295,527).

However, as discussed in the Collection of Information (section IV. of this proposed rule) the Federal Government, through Federal Financial Participation, has a share in State Medicaid expenditures. For the purposes of this proposal, we have estimated that the Federal share of States' Medicaid expenditures is 50 percent. This means that the States and the Federal Government will each have a 50 percent share in the costs estimated in the prior paragraph. Therefore, we estimate that the States' and Federal Government's shares of the implementation costs for the proposals would be $430,942 ($861,864 × 0.5) and ongoing annual costs once the requirements took effect of $196,498 ($392,997 × 0.5).

As discussed in the Collection of Information (section IV. of this proposed rule) we estimate that the total cost to providers to prepare for compliance with the reporting requirement proposed at § 442.43(b) and (c) would be $36,560,002, and an annual total cost to providers of $17,912,717.

We do not estimate a cost to providers for the website posting requirement proposed at § 442.43(d). We also do not anticipate costs to beneficiaries associated with either the proposed reporting requirement or the proposed website posting requirement.

Table 29 provides a detailed summary of the estimated costs of each of the provisions for States, the Federal Government, and providers. Table 30 summarizes the estimated costs of the provisions in § 442.43 for States, the Federal Government, and providers (Nursing Care Facilities (NAICS 623110) and Residential Intellectual and Developmental Disabilities Facilities (NAICS 623210)), over 10 years. Aside from regulatory review costs (discussed in the next section) this comprises the entirety of anticipated quantifiable costs associated with proposed changes to part 442, subpart B. The implementation costs associated with the proposed reporting and website posting requirements are split evenly over the years leading up to the proposed effective date, which is 4 years from the final rule's publication. For States and the Federal Government, this means that the implementation costs are represented as $107,736 per year for 4 years ($430,942 estimated implementation costs/4 years). For providers, the implementation costs are represented as $9,140,000 per year for 4 years ($36,560,002 estimated implementation costs/4 years). We also anticipate that once the rule goes into effect in Year 5, the ongoing annual costs will be relatively stable. We have shown the recurring annual estimate for Years 5–10 in Table 30. The estimates below do not account for higher costs associated with medical care; the costs calculated here are related exclusively to reporting and website posting costs. Per OMB guidelines, the projected estimates for future years are reported in real (non-inflation-indexed) dollars.

As discussed in the Collection of Information (section IV. of this proposed rule), costs were based on: (1) the number of States (including Washington, DC and certain territories) that currently operate Medicaid programs that cover nursing facility or ICF/IID services; (2) the number of States that deliver long-term services and supports through managed care; and (3) the total number of freestanding Medicaid-certified nursing facility and ICF/IID facilities in all States. We do not anticipate the number of entities changing significantly over the 10 years included in the cost calculations.

TABLE 29—IMPLEMENTATION AND ANNUAL COSTS DETAILED

	Cost to states ($)	Cost to federal ($)	Costs to providers ($)	Implementation burden overall total ($)	Ongoing annual burden overall total ($)
Reporting—Implementation	311,275	311,275	36,560,002	37,182,552	.....
Reporting—Recurring annual starting Year 5	48,735	48,735	17,912,717	.....	18,010,187
Website—Implementation	119,667	1196,667	0	239,333	.....
Website—Recurring annual starting Year 5	147,763	147,763	0	.....	295,526

TABLE 29—IMPLEMENTATION AND ANNUAL COSTS DETAILED—Continued

	Cost to states ($)	Cost to federal ($)	Costs to providers ($)	Implementation burden overall total ($)	Ongoing annual burden overall total ($)
Total	627,440	627,440	54,472,719	37,421,886	18,305,713

TABLE 30—PROJECTED DISTRIBUTION OF COSTS FOR PROPOSED UPDATES TO 42 CFR 442 SUBPART B

Year	State costs	Federal costs	Provider costs	Total costs associated with § 442.43
1	107,736	107,736	9,140,000	9,355,472
2	107,736	107,736	9,140,000	9,355,472
3	107,736	107,736	9,140,000	9,355,472
4	107,736	107,736	9,140,000	9,355,472
5	196,498	196,498	17,912,717	18,305,713
6	196,498	196,498	17,912,717	18,305,713
7	196,498	196,498	17,912,717	18,305,713
8	196,498	196,498	17,912,717	18,305,713
9	196,498	196,498	17,912,717	18,305,713
10	196,498	196,498	17,912,717	18,305,713
10 Year Total Cost	1,609,930	1,609,930	144,036,304	147,256,164

b. Benefits of Medicaid Institutional Payment Transparency Reporting

Our proposal is intended to support the sufficiency of the direct care and support staff workforce through public reporting of the direct payments to these workers. The immediate benefits (and the intermediate costs in the cause-and-effect chain connecting reporting to long-term benefits) are difficult to quantify. However, we believe that these provisions, if finalized, will pave the way for long-term benefits to Medicaid beneficiaries and help hold States accountable for ensuring that Medicaid payments are sufficient to enlist enough workers so that high quality LTSS are available to the beneficiaries who want and require such care.

We believe that compensation levels are a factor in the creation of a stable workforce, and that a stable workforce will result in better qualified employees, lower turnover, and a higher quality of care.[188] [189] If individuals are attracted to the institutional LTSS workforce and incentivized to remain employed in it, the workforce is more likely to be comprised of workers with the training, expertise, and experience to meet the diverse and often complex needs of individuals with disabilities and older adults residing in institutions. As discussed above, a consistent, adequate direct care workforce can reduce reliance on overtime and costlier temporary staff and reduce the incidence of emergency department visits and hospitalizations.[190] [191] [192]

There are many factors that contribute to understaffing in institutional settings. We are constantly seeking opportunities to address these challenges through guidance, policies, and rulemaking. These provisions in this proposed rule are intended to promote transparency around compensation for direct care workers and support staff. We believe that gathering and sharing data about the amount of Medicaid payments going to the compensation of workers is a critical step in the larger effort to understand the ways we can enact future policies that support the institutional care workforce.

c. Transfers Associated With Medicaid Institutional Payment Transparency Reporting

We do not estimate transfers associated with these proposed provisions.

D. Alternative Direct Care Staff HPRD Requirement Considered

As detailed in this proposed rule, despite the existing requirements and the efforts to improve safety, as well as residents' quality of care and quality of life through the revisions in the 2016 final rule, understaffing in LTC facilities continues to be a concern. We believe the changes we have proposed are consistent with current standards of practice and necessary to increase resident safety and quality of care. We acknowledge, however, there are multiple avenues for establishing a minimum nurse staffing requirement and solicit comments on alternative policy options, including a specific comment solicitation in the ''Provisions of the Proposed Regulation'' section.

In developing the proposed rule, we considered varying staffing models that are available and different approaches we could have adopted for the proposed minimum nurse staffing requirement. We could have adopted multiple different types of combinations of a

[188] See, for example, the discussion of low wages among direct care workers in Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI *http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.*

[189] See, for example, the discussion of the relationship between staff turnover and nursing home quality in Zheng Q, Williams CS, Shulman ET, White AJ. Association between staff turnover and nursing home quality—evidence from payroll-based journal data. J Am Geriatr Soc. 2022 Sep;70(9):2508–2516. doi: 10.1111/jgs.17843. Epub 2022 May 7. PMID: 35524769.

[190] Ochieng, N., Chidambaram, P., Musumeci, M. Nursing Facility Staffing Shortages During the COVID–19 Pandemic. Apr 04, 2022. Kaiser Family Foundation. Accessed at *https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/.*

[191] Harrington, C., Carrillo, H., Garfield, R., Squires, E. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016. Apr 03, 2018. Kaiser Family Foundation. Accessed at *https://www.kff.org/report-section/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016-staffing-levels/.*

[192] Min A, Hong HC. Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A Cross-sectional study using the US Nursing Home Compare database. Geriatr Nurs. 2019 Mar-Apr;40(2):160–165. doi: 10.1016/j.gerinurse.2018.09.010. Epub 2018 Oct 4. PMID: 30292528.

staffing requirement such as separate requirements for RNs, LVNs/LPNs, and NAs or defining requirements for licensed nurse staffing, that is, combining RNs and LVNs/LPNs or creating standards for NAs only. Alternatively, we could have adopted non-nurse staffing requirements such as social workers, therapists, feeding assistants and other non-nurse staffing types in the minimum staffing requirement. Alternative minimum staffing policy options could also focus on the need to increase or decrease the number of HPRD or FTEs by nurse staff and/or type or on specifying the number by shift (including day, evening, night, or weekends or over a 24-hour period).

Ultimately, we chose the comprehensive 24/7 RN and 0.55 RN and 2.45 NA HPRD requirements in this proposed rule to strike a balance between ensuring resident health and safety, while preserving access to care, including discharge to community-based services. We considered a staffing standard that would maintain the 24/7 and 2.45 NA HPRD requirements but would have a lower RN HPRD requirement. We found, however, that even a small reduction in the RN HPRD requirement would lead to a large decline in quality of care. For example, the 2022 Nursing Home Staffing Study [193] found that reducing the case-mix adjusted RN HPRD requirement to between 0.45 and 0.52 hours per resident day would lead the staffing standard to have a smaller impact on Medicare savings, reduced hospitalizations and ED visits, and fewer community discharges. More specifically, the number of reduced hospitalizations would decline from 10,445 to 5,781, the number of reduced ED visits would decline from 7,525 to 4,466, increased community discharges would decline from 5,798 to 3,930, and Medicare savings would decline by more than $130 million annually.

We seek comments on choosing a lower HPRD minimum staffing requirement. In particular, how a lower minimum staffing requirement may influence quality of care and resident safety, as well as access to care.

We also considered alternative minimum staffing requirements at higher levels than the one we proposed. To illustrate this approach, we considered an alternative minimum staffing requirement that would retain the 24/7 RN requirement but would increase the minimum HPRD requirement. More specifically, this alternative minimum requirement would include a minimum staffing level of 0.55 RN HPRD, 2.45 NA HPRD, and 3.48 total nurse staff (RN, LPN/LVN, NA) HPRD. It is important to note that these estimates do not include the exemption criteria, which could significantly reduce the rule's cost.

To estimate the incremental impact of the Minimum Nurse Staffing Requirement of 0.55 RN HPRD, 2.45 NA HPRD, and 3.48 total nurse staff HPRD, we used the same methodology described in section VI.C.1 to first estimate the cost of facilities meeting the 0.55 RN and 2.45 NA hours per resident day, minimum staffing requirement. After accounting for any increase in RN and NA hours per resident day needed to meet the 0.55 RN and 2.45 NA requirements, we then calculated the total number of additional hours per resident day of nurse care that LTC facilities would need to provide to meet the 3.48 HPRD total nurse staff requirement. We did this calculation by subtracting the total nurse staff hours (RN, LVN/LPN, and NA) provided from 3.48 using the following formula: [3.48 – (RN HPRD +LVN/LPN HPRD + NA HPRD)]. For any facilities that were below the 3.48 total nurse staff requirement, we assumed that they would hire NAs to fulfill any remaining hours. Using this strategy, we estimate that this alternative HPRD option would have an annual cost of approximately $4.25 billion for all facilities.

This $4.25 billion estimate assumed that LTC facilities would respond to the minimum staffing requirement by increasing their RN and NA staffing levels to the level necessary to meet the requirements, without reducing other staff such as administrative staff. We also assumed LTC facilities that were above the minimum staffing requirements for RNs or total nurse staff hours per resident day would not decrease their staffing levels to the mandated minimum. Finally, we assumed that LTC facilities would not lay off LVNs/LPNs and replace them with NAs, who are less costly. If facilities covered under this proposed rule reduced other staff not covered by the rule, reduced nurse staff levels to the mandate minimum, or they obtained exemptions from the minimum staffing requirements, the requirement's cost and benefits could decline significantly relative to what is presented above. Non-quantified effects, such as costs associated with LTC closure or reduction in patient load per facility, would also be reduced).

Table 31 summarizes the 10-year total cost for this alternative minimum nurse staffing proposal in 2021 US dollars. The total cost for this alternative proposal included the 24/7 RN requirement, the 3.48 HPRD requirement, and any associated collection of information costs as described in section IV. Collection of Information Requirement. To account for changes in real nurse staff wages over time, we assumed that real wages would rise at a rate of 2.31 percent annually. Since this estimate continued to assume that the rule would have different phase-in periods for rural and urban LTC facilities to meet the 24/7 RN (2 years for facilities in urban areas and 3 years for facilities in rural areas) and the 0.55 RN HPRD, 2.45 NA HPRD, and 3.48 total nurse staff (RN, LPN/LVN, NA) HPRD (3 years for facilities in urban areas and 5 years for facilities in rural areas) requirements, we provided separate estimates for facilities located in each area. Over a 10-year period, we anticipated an average annual cost of approximately $4.08 billion.

TABLE 31—COST FOR ALTERNATIVE MINIMUM NURSE STAFFING REQUIREMENT OF 3.48 TOTAL HOURS PER RESIDENT DAY

Year	Collection of information costs for 24/7 RN (§ 483.35 nursing services)	Collection of information costs for facility assessment (§ 483.71 facility assessment)	24/7 RN Requirement (urban facilities)	24/7 RN Requirement (rural facilities)	0.55 RN, 2.45 NA, and 3.48 total nurse HPRD Requirement (urban facilities)	0.55 RN, 2.45 NA, and 3.48 total nurse HPRD requirement (rural facilities)	Total cost
1	$7,461,504	$24,176,448	$0	$0	$0	$0	$31,637,952
2	7,633,865	24,734,924	213,764,107	0	0	0	246,132,896

[193] Please see Exhibit 4.50. Predicted Medicare Savings and Changes in Utilization for Potential Minimum RN Staffing Options.

TABLE 31—COST FOR ALTERNATIVE MINIMUM NURSE STAFFING REQUIREMENT OF 3.48 TOTAL HOURS PER RESIDENT DAY—Continued

Year	Collection of information costs for 24/7 RN (§ 483.35 nursing services)	Collection of information costs for facility assessment (§ 483.71 facility assessment)	24/7 RN Requirement (urban facilities)	24/7 RN Requirement (rural facilities)	0.55 RN, 2.45 NA, and 3.48 total nurse HPRD Requirement (urban facilities)	0.55 RN, 2.45 NA, and 3.48 total nurse HPRD requirement (rural facilities)	Total cost
3	7,810,207	25,306,301	218,702,058	146,603,030	3,675,431,549	0	4,073,853,145
4	7,990,623	25,890,876	223,754,076	149,989,560	3,760,334,018	0	4,167,959,153
5	8,175,206	26,488,955	228,922,795	153,454,319	3,847,197,733	808,635,699	5,072,874,708
6	8,364,053	27,100,850	234,210,912	156,999,114	3,936,068,001	827,315,184	5,190,058,114
7	8,557,263	27,726,880	239,621,184	160,625,793	4,026,991,172	846,426,164	5,309,948,456
8	8,754,936	28,367,371	245,156,433	164,336,249	4,120,014,668	865,978,609	5,432,608,265
9	8,957,175	29,022,657	250,819,547	168,132,416	4,215,187,007	885,982,714	5,558,101,516
10	9,164,086	29,693,081	256,613,478	172,016,275	4,312,557,827	906,448,915	5,686,493,661
10 Year Total Cost	82,868,918	268,508,343	2,111,564,589	1,272,156,756	31,893,781,974	5,140,787,285	40,769,667,866

As we have previously noted, this rule does not require payors to increase payment rates to providers to meet the expected costs of the minimum staffing and 24/7 RN requirements. Below, however, we provide estimates of how much of facilities' costs to meet the minimum staffing and 24/7 RN requirements are due to residents whose stays are covered by Medicaid, Medicare, and other non-Medicare/Medicaid payors.

Table 32 lays out the share of the facility's cost to meet the requirement that is due to residents utilizing Medicaid, with an average annual cost of approximately $2.68 billion in 2021 US dollars over a 10-year period. Table 33 lays out the share of the facility's cost that is due to residents utilizing Medicare and other non-Medicare/Medicaid payors, with an average annual cost of approximately $453 million for Medicare and $884 million for other payors in 2021 US dollars over a 10-year period. These estimates were based on the assumptions listed in section VI.C.1.a.(3) of this proposed rule.

We seek comments on choosing a higher HPRD minimum staffing requirement. In particular, we welcome comments regarding how a higher minimum staffing requirement may influence quality of care and resident safety, as well as access to care.

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TABLE 32: Cost of Alternative Comprehensive Minimum Nurse Staffing Requirement of 3.48 Total Hours per Resident Day Due to Residents Whose Stay is Covered by Medicaid

Year	24/7 RN State Medicaid Cost (Rural Facilities)	24/7 RN Federal Medicaid Cost (Rural Facilities)	24/7 RN State Medicaid Cost (Urban Facilities)	24/7 RN Federal Medicaid Cost (Urban Facilities)	State Medicaid Cost for 0.55 RN, 2.45 NA, and 3.48 Total Nurse HPRD Requirement (Rural Facilities)	Federal Medicaid Cost for 0.55 RN, 2.45 NA, and 3.48 Total Nurse HPRD Requirement (Rural Facilities)	State Medicaid Cost for 0.55 RN, 2.45 NA, and 3.48 Total Nurse HPRD Requirement (Urban Facilities)	Federal Medicaid Cost for 0.55 RN, 2.45 NA, and 3.48 Total Nurse HPRD Requirement (Urban Facilities)	Total State Medicaid Cost	Total Federal Medicaid Cost
1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
2	$0	$0	$54,253,616	$83,512,408	$0	$0	$0	$0	$54,253,616	$83,512,408
3	$36,575,549	$62,192,075	$55,506,875	$85,441,545	$0	$0	$1,031,567,565	$1,402,814,360	$1,123,649,989	$1,550,447,980
4	$37,420,445	$63,628,712	$56,789,084	$87,415,245	$0	$0	$1,055,396,776	$1,435,219,371	$1,149,606,305	$1,586,263,328
5	$38,284,857	$65,098,535	$58,100,912	$89,434,537	$206,837,807	$340,045,093	$1,079,776,441	$1,468,372,939	$1,383,000,018	$1,962,951,103
6	$39,169,237	$66,602,312	$59,443,043	$91,500,475	$211,615,761	$347,900,134	$1,104,719,277	$1,502,292,354	$1,414,947,318	$2,008,295,275
7	$40,074,046	$68,140,825	$60,816,177	$93,614,136	$216,504,085	$355,936,627	$1,130,238,292	$1,536,995,307	$1,447,632,600	$2,054,686,895
8	$40,999,757	$69,714,878	$62,221,031	$95,776,622	$221,505,329	$364,158,763	$1,156,346,797	$1,572,499,899	$1,481,072,914	$2,102,150,162
9	$41,946,851	$71,325,292	$63,658,336	$97,989,062	$226,622,102	$372,570,831	$1,183,058,408	$1,608,824,646	$1,515,285,697	$2,150,709,831
10	$42,915,824	$72,972,906	$65,128,844	$100,252,610	$231,857,073	$381,177,217	$1,210,387,057	$1,645,988,496	$1,550,288,798	$2,200,391,229
10 Year Total Cost	$317,386,566	$539,675,535	$535,917,918	$824,936,640	$1,314,942,158	$2,161,788,666	$8,951,490,613	$12,173,007,371	$11,119,737,254	$15,699,408,212

BILLING CODE 4120–01–C

TABLE 33: Cost of Alternative Comprehensive Minimum Nurse Staffing Requirement of 3.48 Total Hours per Resident Day due to Residents whose Stay is Covered by Medicare and Other non-Medicare/Medicaid Payors

Year	24/7 RN Medicare Cost (Rural Facilities)	24/7 RN Medicare Costs (Urban Facilities)	0.55 RN, 2.45 NA, and 3.48 Total Nurse HPRD Requirement Medicare Cost (Rural Facilities)	0.55 RN, 2.45 NA, and 3.48 Total Nurse HPRD Requirement Medicare Cost (Urban Facilities)	24/7 RN Other Non-Medicaid Payors Cost (Rural Facilities)	24/7 RN Other Non-Medicaid Payors Costs (Urban Facilities)	0.55 RN, 2.45 NA, and 3.48 Total Nurse HPRD Requirement Other Non-Medicaid Payors Cost (Rural Facilities)	0.55 RN, 2.45 NA, and 3.48 Total Nurse HPRD Requirement Other Non-Medicaid Payors Cost (Urban Facilities)	Total Cost Due to Residents whose Stay is Covered by Medicare	Total Cost Due to Residents whose Stay is Covered by Other non-Medicare/Medicaid Payors
1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
2	$0	$26,252,999	$0	$0	$0	$49,745,083	$0	$0	$26,252,999	$49,745,083
3	$12,665,283	$26,859,443	$0	$415,924,560	$35,170,123	$50,894,195	$0	$802,437,832	$455,449,286	$888,502,150
4	$12,957,851	$27,479,897	$0	$425,532,417	$35,982,552	$52,069,851	$0	$820,974,146	$465,970,165	$909,026,549
5	$13,257,177	$28,114,682	$87,289,672	$435,362,216	$36,813,749	$53,272,664	$170,600,165	$839,938,648	$564,023,748	$1,100,625,227
6	$13,563,418	$28,764,131	$89,306,064	$445,419,084	$37,664,147	$54,503,263	$174,541,029	$859,341,231	$577,052,696	$1,126,049,671
7	$13,876,733	$29,428,583	$91,369,034	$455,708,264	$38,534,189	$55,762,288	$178,572,927	$879,192,014	$590,382,614	$1,152,061,418
8	$14,197,285	$30,108,383	$93,479,658	$466,235,125	$39,424,329	$57,050,397	$182,697,962	$899,501,349	$604,020,452	$1,178,674,037
9	$14,525,243	$30,803,887	$95,639,039	$477,005,157	$40,335,031	$58,368,261	$186,918,285	$920,279,830	$617,973,325	$1,205,901,407
10	$14,860,776	$31,515,456	$97,848,300	$488,023,976	$41,266,770	$59,716,568	$191,236,097	$941,538,294	$632,248,508	$1,233,757,729
Total 10 Year Cost	$109,903,766	$259,327,462	$554,931,767	$3,609,210,800	$305,190,890	$491,382,570	$1,084,566,465	$6,963,203,345	$4,533,373,794	$8,844,343,270

2. Medicaid Institutional Payment Transparency Reporting

We considered proposing to require in § 442.43(b) that States report at the beneficiary level or other more granular levels but did not include such requirements because we expected that this would increase reporting burden for States and providers without giving us additional information necessary for determining the percent of payments that are going to the workforce.

We also considered whether to allow States, at their option, to exclude from their reporting to CMS payments to providers that have low Medicaid revenues or serve a small number of Medicaid beneficiaries, based on Medicaid revenues for the service, or the number of Medicaid beneficiaries receiving the service. We considered this option as a way to reduce State and provider data collection and reporting burden based on the experience of States that have implemented similar reporting requirements. However, we are concerned that such an option could discourage providers from serving Medicaid beneficiaries or increasing the number of Medicaid beneficiaries served.

E. Regulatory Review Costs

1. Regulatory Review Costs of 24/7 RN and 0.55 RN and 2.45 NA HPRD Minimum Nurse Staffing

If the 24/7 RN and the Minimum Nurse staffing proposals impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. As discussed in the Collection of Information (section III. of this proposed rule), 14,688 LTC facilities would be impacted by the proposed requirements. We assume that seventy-five percent (75 percent) of LTC facilities will proactively review this proposed rule, or 11,016. (We note that the FY 2023 SNF PPS proposed rule, 87 FR 22720, had around 18,000 views, as shown at *https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.* Some of these views were likely multiple views by the same reader.) We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all of the affected LTC facilities will read this proposed rule, or that there may be more than one individual reviewing the rule for some LTC facilities. It is also possible that entities other than LTC facilities, such as beneficiary advocacy groups, may review this rule. We welcome any comments on the approach in estimating the number of LTC facilities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of some proposed rules, or that some entities may not find it necessary to fully read each rule, and therefore for the purposes of our estimate we assume that each reviewer will read approximately 50 percent of the section of the rule discussing the 24/7 RN requirement and the 0.55 RN and 2.45 NA HPRD requirement.

We seek comments on this assumption.

Using the wage information from the Bureau of Labor Statistics, May 2022 National Occupational Employment and Wage Estimates, *https://www.bls.gov/oes/current/oes_nat.htm,* for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $123.06 per hour, including overhead and fringe benefits. Assuming an average reading speed of 250 words per minute, and assuming that two-thirds (67 percent) of this proposed rule pertains to the 24/7 RN and 0.55 RN and 2.45 NA HPRD requirement, with approximately 40,000 words (of which we estimate 20,000 words will be read by reviewers), we estimate that it would take 80 minutes or 1.33 hours for the staff to review all the sections of the proposed rule pertaining to the 24/7 RN and 0.55 RN and 2.45 NA HPRD requirements. For each employee that reviews the rule, the estimated cost is $163.67 (1.33 hours × $123.06). Therefore, we estimate that the total one-time cost of reviewing this regulation is $1,802,989 (163.67 × 11,016).

2. Regulatory Review Costs of Medicaid Institutional Payment Transparency Reporting

As discussed in the Collection of Information (section III. of this proposed rule), 52 State Medicaid agencies and approximately 19,907 nursing facilities and ICF/IIDs would be impacted by the proposed requirements (totaling 19,959 interested parties). Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that seventy-five percent (75 percent) of these affected entities will proactively review this proposed rule, or 14,969. (We note that the FY 2023 SNF PPS proposed rule, 87 FR 22720, had around 18,000 views, as shown at *https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.* Some of these views were likely multiple views by the same reader.) We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all those affected entities will read this proposed rule, or that there may be more than one individual reviewing the rule for some of the affected entities. It is also possible that entities other than State Medicaid agencies or institutional facilities, such as beneficiary advocacy groups, may review this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of some proposed rules, or that some entities may not find it necessary to fully read each rule, and therefore for the purposes of our estimate we assume that each reviewer will read half of the sections of the rule discussing Medicaid institutional payment adequacy. We seek comments on this assumption.

Using the wage information from the Bureau of Labor Statistics, May 2022 National Occupational Employment and Wage Estimates, *https://www.bls.gov/oes/current/oes_nat.htm,* for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $123.06 per hour, including overhead and fringe benefits. Assuming an average reading speed of 250 words per minute, and assuming that one-third of this rule pertains to Medicaid Institutional Payment Transparency Reporting, with approximately 20,000 words (of which we estimate 10,000 words will be read by reviewers), we estimate that it would take 40 minutes or 0.67 hours for the staff to review portions of the sections of the proposed rule pertaining to the Medicaid Institutional Payment Transparency Reporting. For each employee that reviews the rule, the estimated cost is $82.45 (0.67 hours × $123.06). Therefore, we estimate that the total one-time cost of reviewing this regulation is $1,234,194 ($82.45 × 14,969).

Table 34 provides the total estimated regulatory review costs for the rule, which is $3,037,183.

TABLE 34—REGULATORY REVIEW COST

Medicaid institutional payment transparency reporting	24/7 RN and 0.55 RN and 2.45 NA HPRD minimum nurse staffing	Total cost
$1,234,194	$1,802,989	$3,037,183

F. Accounting Statement

As required by OMB Circular A–4 (available online at *https://obamawhitehouse.archives.gov/omb/circulars_a004_a-4/*), we have prepared an accounting statement in Table 34 showing classification of the costs and benefits associated with the provisions of this proposed rule. This includes the total cost for the 24/7 RN and the 0.55 RN and 2.45 NA HPRD requirements as provided in Table 20, the total cost for the Medicaid Institutional Transparency Reporting as provided in Table 30, the total cost for the regulatory review as provided in Table 34, and Medicare savings due to fewer hospitalizations and emergency department visits, as well as greater return to home and community, as provided in Table 28. There are $0 in transfer estimates in the statement. This statement provides our best estimate for the Medicare and Medicaid provisions of this rule.

TABLE 35—ACCOUNTING STATEMENT: 24/7 RN REQUIREMENT, 0.55 RN AND 2.45 NA HPRD REQUIREMENT, AND MEDICAID INSTITUTIONAL PAYMENT TRANSPARENCY REPORTING REQUIREMENT

Category	Estimates	Units		
		Year dollar	Discount rate	Period covered
Benefits				
Annualized Monetized ($million/year)	236 247	2021 2021	7% 3	2024–2033 2024–2033
Costs				
Annualized Monetized ($million/year)	3,733 3,930	2021 2021	7% 3	2024–2033 2024–2033

G. Regulatory Flexibility Act Analysis (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that almost all Skilled Nursing Facilities (NAICS 6231) and Intellectual and Developmental Disabilities Facilities (NAICS 6232) are small entities, as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (that is, having revenues of less than $8.0 million to $41.5 million in any 1 year).

We utilized the revenues of individual SNF *providers* (from recent Medicare Cost Reports) to classify a small business, and not the revenue of a larger firm with which they may be affiliated. As a result, for the purposes of the RFA, we estimate that almost all SNFs are small entities as that term is used in the RFA, according to the Small Business Administration's latest size standards, with total revenues of $34 million or less in any 1 year. In addition, approximately 20 percent of SNFs classified as small entities are non-profit organizations. Therefore, approximately 95 percent of the health care industries impacted are considered small businesses according to the Small Business Administration's size standards with total revenues of $41 million or less in any 1 year. Individuals and States are not included in the definition of a small entity. According to the 2017 Economic Census, Skilled Nursing Facilities (NAICS 6231) and Intellectual and Development Disabilities Facilities (NAICS 6232) together earned approximately $162 billion annually with Skilled Nursing Facilities earning nearly $119 billion and Intellectual and Development Disabilities Facilities earning approximately $44 billion. Overall, the cost is estimated to be between 2.30 and 2.42 percent of revenues.

TABLE 36—REGULATORY FLEXIBILITY ACT ANALYSIS

	Annual revenue	Estimated average annual cost for providers with 3% discount rate	Estimated average annual cost for providers with 7% discount rate	Cost as % of revenue with 3% discount rate	Cost as % of revenue with 7% discount rate
Skilled Nursing Facilities and Intellectual and Developmental Disabilities Facilities	$162,451,136,000	$3,733,000,000	$3,930,000,000	2.30	2.42

Individuals and States are not included in the definition of a small entity. This rule will not have a significant impact measured change in revenue of 3 to 5 percent on a substantial number of small businesses or other small entities. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. At this time, we do not believe that this threshold will be reached by the requirements in this proposed rule. Therefore, the Secretary has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. These proposals pertain solely to SNFs and NFs. Therefore, the Secretary has determined that these proposals will not have a significant impact on the operations of a substantial number of small rural hospitals.

H. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. Based on the cost estimates discussed in this section, we have assessed the various costs and benefits of the proposed updates to the requirements for participation for LTC facilities. These proposed updates will not impose new requirements for State, local, or tribal governments. For the private sector facilities, the regulatory impact section, together with the remainder of the preamble, constitutes the analysis required under UMRA.

I. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. With regard to the updates to the requirements for participation for LTC facilities, the provisions in this proposed rule are not intended to, and would not preempt the applicability of any State or local law providing a higher standard (in this case, a higher HPRD requirement for RNs and/or NAs or an RN coverage requirement in excess of at least one RN on site 24-hours per day, 7 days a week) than would be required by this proposed rule. To the extent Federal standards exceed State and local law minimum staffing standards, no Federal pre-emption is implicated because facilities complying with Federal law would also be in compliance with State law. We are not aware of any State or local law providing for a maximum staffing level. This proposed rule, however, is intended to and would preempt the applicability of any State or local law providing for a maximum staffing level, to the extent that such a State or local maximum staffing level would prohibit a Medicare, Medicaid, or dually certified LTC facility from meeting the minimum HPRD requirements and RN coverage levels proposed in this rule or from meeting higher staffing levels required based on the facility assessment proposed in this rule.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on August 15, 2023.

List of Subjects

42 CFR Part 438

Administrative practice and procedure, Grant programs—health, Health professions, Medicaid, Older adults, People with Disabilities, Reporting and recordkeeping requirements.

42 CFR Part 442

Administrative practice and procedure, Grant programs—health, Health professions, Medicaid, Older adults, People with Disabilities, Reporting and recordkeeping requirements.

42 CFR Part 483

Grant programs—health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 438—MANAGED CARE

■ 1. The authority citation for part 438 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 2. Section 438.72 is added to subpart B to read as follows:

§ 438.72 Additional requirements for long-term services and supports.

(a) *Nursing facilities services and services delivered in Intermediate Care Facilities for Individuals with Intellectual Disabilities.* If the State includes nursing facility and/or ICF/IID services in their MCO or PIHP contracts, the State must include requirements in these contracts imposing obligations on the MCO or PIHP to the extent necessary to comply with the reporting requirements in § 442.43 of this subchapter, and must comply by the first rating period for contracts with MCOs or PIHPs beginning on or after the effective date specified in § 442.43(f) of this subchapter.

(b) [Reserved]

PART 442—STANDARDS FOR PAYMENT TO NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

■ 3. The authority citation for part 442 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.

■ 4. Section 442.43 is added to subpart B to read as follows:

§ 442.43 Payment Transparency Reporting.

(a) *Definitions.* (1) *Compensation* means, with respect to direct care workers and support staff delivering services authorized under this part:

(i) Salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations (29 U.S.C. 201 *et seq.,* 29 CFR parts 531 and 778);

(ii) Benefits (such as health and dental benefits, sick leave, and tuition reimbursement); and

(iii) The employer share of payroll taxes.

(2) *Direct Care Worker* means one of the following individuals who provides services to Medicaid-eligible individuals receiving services under this part, who may be employed by or contracted or subcontracted with a Medicaid provider or State or local government agency:

(i) A registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist;

(ii) A certified nurse aide who provides services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist;

(iii) A licensed physical therapist, occupational therapist, speech-language pathologist, or respiratory therapist;

(iv) A certified physical therapy assistant, occupational therapy assistant, speech-language therapy assistant, or respiratory therapy assistant or technician;

(v) A social worker;

(vi) A personal care aide;

(vii) A medication assistant, aide, or technician;

(viii) A feeding assistant;

(ix) Activities staff; or

(x) Any other individual who is paid to provide clinical services, behavioral supports, active treatment (as defined at § 483.440) or address activities of daily living (such as those described in § 483.24(b)) for Medicaid-eligible individuals receiving Medicaid services under this part.

(3) *Support Staff* means an individual who is not a direct care worker and who maintains the physical environment of the care facility or supports other services for residents. Support staff may be employed by or contracted or subcontracted with a Medicaid provider or State or local government agency. They include any of the following individuals:

(i) A housekeeper;

(ii) A janitor or environmental services worker;

(iii) A groundskeeper;

(iv) A food service or dietary worker;

(v) A driver responsible for transporting residents; or

(vi) Any other individual who is not a direct care worker and who maintains the physical environment of the care facility or supports other services for Medicaid-eligible individuals receiving Medicaid services under this part.

(b) *Reporting requirements.* The State must report to CMS annually, by delivery system and by facility, the percent of Medicaid payments (which for fee-for-service includes base and supplemental payments as defined by section 1903(bb)(2) of the Social Security Act, and for payments from a managed care organization or prepaid inpatient health plan (as these entities are defined in § 438.2 of this chapter) includes the managed care organization's or prepaid inpatient health plan's contractually negotiated rate, State directed payments as defined in § 438.6(c) of this chapter, pass-through payments as defined in § 438.6(a) of this chapter for nursing facilities, and any other payments from the managed care organization or prepaid inpatient health plan) for services specified in paragraph (b)(1) of this section, that is spent on compensation for direct care workers and on compensation for support staff, at the time and in the form and manner specified by CMS.

(1) *Services.* Except as provided in paragraph (b)(2) of this section, reporting must be based on all Medicaid payments (including but not limited to FFS base and supplemental payments, and payments from an MCO or PIHP, as applicable) made to nursing facility and ICF/IID providers for Medicaid-covered services, with the exception of services provided in swing bed hospitals as defined in § 440.40(a)(1)(ii)(B) of this chapter.

(2) *Exclusion of specified payments.* The State must exclude from its reporting to CMS payments claimed by the State for Federal financial participation under this part for which Medicaid is not the primary payer.

(c) *Report contents and methodology.* (1) *Contents.* Reporting must provide information necessary to identify, at the facility level, the percent of Medicaid payments spent on compensation to:

(i) Direct care workers at each nursing facility;

(ii) Support staff at each nursing facility;

(iii) Direct care workers at each ICF/IID, and

(iv) Support staff at each ICF/IID.

(2) *Methodology.* The State must provide information according to the methodology, form, and manner of reporting stipulated by CMS.

(d) *Availability and accessibility requirements.* The State must operate a website consistent with § 435.905(b) of this chapter that provides the results of the reporting requirements specified in paragraphs (b) and (c) of this section. In the case of the State that implements a managed care delivery system under the authority of sections 1915(a), 1915(b), 1932(a), and/or 1115(a) of the Act and that includes nursing facility and/or ICF/IID services in their managed care organization or prepaid inpatient health plan contracts, the State may meet this requirement by linking to individual managed care organization or prepaid inpatient health plan websites. The State must:

(1) Include clear and easy to understand labels on documents and links;

(2) Verify no less than quarterly, the accurate function of the website and the current accuracy of the information and links; and

(3) Include prominent language on the website explaining that assistance in accessing the required information on the website is available at no cost and include information on the availability of oral interpretation in all languages and written translation available in each non-English language, how to request auxiliary aids and services, and a toll-free and TTY/TDY telephone number.

(e) *Information reported by States.* CMS must report on its website the results of the reporting requirements specified in paragraphs (b) and (c) of this section that the State reports to CMS.

(f) *Effective Date.* The requirements in this section are effective [4 YEARS AFTER THE EFFECTIVE DATE OF THE FINAL RULE].

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

■ 5. The authority citation for part 483 continues to read as follows:

Authority: 42 U.S.C. 1302, 1320a–7, 1395i, 1395hh and 1396r.

■ 6. Amend § 483.5 by adding the definitions of ''Hours per resident day'' and ''Representative of direct care employees'' in alphabetical order to read as follows:

§ 483.5 Definitions.

* * * * *

Hours per resident day. Staffing hours per resident per day is the total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS.

* * * * *

Representative of direct care employees. A representative of direct care employees is an employee of the facility or a third party authorized by direct care employees at the facility to provide expertise and input on behalf of the employees for the purposes of informing a facility assessment.

* * * * *

§ 483.10 [Amended]

■ 7. Amend paragraph (h)(3)(i) by removing the reference ''§ 483.70(i)(2)'' and adding in its place the reference ''§ 483.70(h)(2)''.

§ 483.15 [Amended]

■ 8. Amend paragraph (c)(8) by removing the reference ''§ 483.70(l)'' and adding in its place the reference ''§ 483.70(k)''.

§ 483.35 [Amended]

■ 9. Amend § 483.35 by:

■ a. In the introductory text removing the reference ''§ 483.70(e)'' and adding in its place the reference ''§ 483.71'';
■ b. Revising paragraphs (a)(1)(i), (ii);
■ c. Adding paragraphs (a)(1)(iii) through (v);
■ d. In paragraph (a)(2) removing the phrase ''paragraph (c)'' and adding in its place the phrase ''paragraph (e)'';
■ e. Revising paragraph (b)(1);
■ f. . In paragraph (e)(4) removing the phrase ''paragraph (c)'' and adding in its place the phrase ''paragraph (e)'';
■ g. In paragraph (f)(2) removing the phrase ''paragraph (d)(1)'' and adding in its place the phrase ''paragraph (f)(1)'';
■ h. Redesignating paragraph (g) as (h);
■ i. Adding a new paragraph (g); and
■ j. In newly redesignated paragraph (h)(2)(i) removing the phrase ''paragraph (e)(1)'' and adding in its place the phrase ''paragraph (h)(1)''.

The revision and additions read as follows:

§ 483.35 Nursing services.

* * * * *

(a) * * *

(1) * * *

(i) Licensed nurses, including but not limited to a minimum 0.55 hours per resident day for registered nurses (RN); and

(ii) Other nursing personnel, in accordance with § 483.71, including but not limited to a minimum total of 2.45 hours per resident day for nurse aides (NA).

(iii) The 0.55 hours per resident day for RN and 2.45 hours per resident day for NA requirement may be exempted under paragraph (g) of this section for facilities that are found non-compliant and meet the eligibility criteria as determined by the Secretary.

(iv) Determinations of compliance with hours per resident day requirements will be made based on the most recent available quarter of Payroll Based Journal System data submitted in accordance with § 483.70(p) of this part.

(v) Compliance with minimum hours per resident day for RN and NA should not be construed as approval for a facility to staff only to these numerical standards. Facilities must ensure there are adequate staff with the appropriate competencies and skills sets necessary to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments, acuity and diagnoses of the facility's resident population in accordance with the facility assessment at § 483.71 of this part.

* * * * *

(b) * * *

(1) Except when waived under paragraph (e) or (f) of this section, the facility must have a registered nurse on site 24 hours per day, for 7 days a week that is available to provide direct resident care.

* * * * *

(g) *Hardship Exemption from the Minimum Hours Per Resident Day Requirements.* A facility may be exempted by the Secretary from the requirements of paragraphs (a)(1)(i) and (ii) of this section if a verifiable hardship exists that prohibits the facility from achieving or maintaining compliance. The facility must meet the four following criteria to qualify for a hardship exemption:

(1) *Location.* The facility is located in an area where:

(i) The supply of applicable healthcare staff (either RN, or NA, or both) is not sufficient to meet area needs as evidenced by a medium (20 percent below the national average) or low (40 percent below the national average) provider-population ratio for nursing workforce; or

(ii) The facility is at least 20 miles from another long-term care facility, as determined by CMS; and

(2) *Good Faith Efforts to Hire.* The facility demonstrates that it has been unable, despite diligent efforts, including offering at least prevailing wages, to recruit and retain appropriate personnel. The information is verified through:

(i) Job listings in commonly used recruitment forums found online at American Job Centers (coordinated by the U.S. Department of Labor's Employment and Training Administration), and other forums as appropriate;

(ii) Documented job vacancies including the number and duration of the vacancies and documentation of offers made, including that they were made at least at prevailing wages;

(iii) Data on the average wages in the Metropolitan Statistical Area in which the facility is located and vacancies by industry as reported by the Bureau of Labor Statistics or by the State's Department of Labor; and

(iv) The facility's staffing plan in accordance with § 483.71(b)(4) of this subpart; and

(3) *Demonstrated Financial Commitment.* The facility demonstrates through documentation the amount of financial resources that the facility expends on nurse staffing relative to revenue.

(4) *Exclusions.* Facilities must not:

(i) Be a Special Focus Facility, pursuant to the Special Focus Facility Program established under sections 1819(f)(8) and 1919(f)(10) of the Act; or

(ii) Have been cited for having widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm, or cited at the immediate jeopardy level of severity with respect to insufficient staffing as determined by CMS, within the 12 months preceding the survey during which the facility's non-compliance is identified, or

(iii) Have failed to submit Payroll Based Journal data in accordance with § 483.70(p).

(iv) An exemption under this paragraph does not constitute a waiver of paragraph (b) of this section. Such a waiver must be granted in accordance with paragraph (e) or (f) of this section.

(5) *Determination of Eligibility.* The Secretary will determine eligibility for an exemption based on the criteria in paragraphs (g)(1) through (4) of this section. The facility must provide supporting documentation when requested.

(6) *Timeframe.* The term for a hardship exemption is 1-year, unless the facility becomes an SFF facility or is cited for widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm. A hardship exemption may be extended on a yearly basis, after the initial 1-year period, if the facility continues to meet the exemption criteria in paragraphs (g)(1) through (4) of this section, as determined by the Secretary. There are no limits on the number of exemptions that an eligible facility can be granted.

* * * * *

§ 483.40 [Amended]

■ 10. Amend § 483.40 by:
■ a. In paragraphs (a) introductory text and (a)(1) removing the reference ''§ 483.70(e)'' and adding in its place the reference ''§ 483.71''; and
■ b. In paragraph (c)(2) by removing the reference ''§ 483.70(g)'' and adding in its place the reference ''§ 483.70(f)''.

§ 483.45 [Amended]

■ 11. Amend § 483.45 in the introductory text by removing the reference ''§ 483.70(g)'' and adding in its place the reference ''§ 483.70(f)''.

§ 483.55 [Amended]

■ 12. In § 483.55 amend paragraphs (a)(1) and (b)(1) by removing the reference ''§ 483.70(g)'' and adding in its place the reference ''§ 483.70(f)''.

§ 483.60 [Amended]

■ 13. In § 483.60 amend paragraph (a) introductory text by removing the

reference ''§ 483.70(e)'' and adding in its place the reference ''§ 483.71''.

§ 483.65 [Amended]

■ 14. In § 483.65 amend paragraph (a)(2) by removing the reference ''§ 483.70(g)'' and adding in its place the reference ''§ 483.70(f)''.

§ 483.70 [Amended]

■ 15. Amend § 483.70 by—
■ a. Removing paragraph (e); and
■ b. Redesignating paragraphs (f) through (q) as paragraphs (e) through (p), respectively.
■ 16. Section § 483.71 is added to subpart B to read as follows:

§ 483.71 Facility Assessment.

The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

(a) The facility assessment must address or include the following:

(1) The facility's resident population, including, but not limited to:

(i) Both the number of residents and the facility's resident capacity;

(ii) The care required by the resident population, using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health issues, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20 of this part;

(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;

(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and

(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

(2) The facility's resources, including but not limited to the following:

(i) All buildings and/or other physical structures and vehicles;

(ii) Equipment (medical and non-medical);

(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;

(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;

(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and

(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in § 483.73(a)(1).

(4) The input of facility staff, including, but not limited to nursing home leadership, management, direct care staff, the representatives of direct care employees, and staff providing other services.

(b) The facility must use this facility assessment to:

(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

(2) Consider specific staffing needs for each resident unit in the facility, and adjust as necessary based on changes to its resident population.

(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.

(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.

(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.

§ 483.75 [Amended]

■ 17. Amend § 483.75 by:
■ a. In paragraph (c)(2) removing the reference ''§ 483.70(e)'' and adding in its place the reference ''§ 483.71''; and
■ b. In paragraph (e)(3) removing the reference ''§ 483.70(e)'' and adding in its place the reference ''§ 483.71''.

§ 483.80 [Amended]

■ 18. In § 483.80 amend paragraph (a)(1) by removing the reference ''§ 483.70(e)'' and adding in its place the reference ''§ 483.71''.

§ 483.95 [Amended]

■ 19. In § 483.95 amend the introductory text by removing the reference ''§ 483.70(e)'' and adding in its place the reference ''§ 483.71''.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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