

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

#### 42 CFR Parts 438, 442, and 483

[CMS–3442–F]

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:** Final rule.

**SUMMARY:** This final rule establishes 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 requires 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:**

*Effective date:* These regulations are effective on June 21, 2024.

*Implementation date:* Except as set forth in this section, these regulations must be implemented upon the effective date.

- The regulations at § 483.71 must be implemented by August 8, 2024, for all facilities.

- The regulations at § 483.35(b)(1) and (c)(1) must be implemented by May 11, 2026, for non-rural facilities and May 10, 2027, for rural facilities as defined by the Office of Management and Budget.

- The regulations at § 483.35(b)(1)(i) and (ii) must be implemented by May 10, 2027, for non-rural facilities and May 10, 2029, for rural facilities as defined by the Office of Management and Budget.

- The regulations at §§ 438.72(a) and 442.43 must be implemented by all States and territories with Medicaid-certified nursing facilities and intermediate care facilities for individuals with intellectual disabilities beginning May 10, 2028.

**FOR FURTHER INFORMATION CONTACT:** The Clinical Standard Group’s Long Term Care Team at [HealthandSafetyInquiries@cms.hhs.gov](mailto: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:** 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 final rule establishes minimum staffing standards to address ongoing safety and quality concerns for the 1.2 million<sup>1</sup> residents receiving services in Medicare and Medicaid certified Long-Term Care (LTC) facilities each day. As we have heard from residents, staff, and advocates across the country in response to the proposed rule, ensuring adequate staffing levels is essential to the safety and quality of long-term care facilities. On February 28, 2022, President Biden announced that CMS would establish minimum staffing standards that nursing homes must meet, based in part on evidence from a new research study that would focus on the level and type of staffing needed to ensure safe and quality care.<sup>2</sup> This announcement was part of an overall reform plan to improve the quality and safety of nursing homes. In addition, on

<sup>1</sup> <https://data.cms.gov/provider-data/dataset/4pq5-n9py>.

<sup>2</sup> <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/>.

April 18, 2023, President Biden issued Executive Order 14095, “Increasing Access to High-Quality Care and Supporting Caregivers,”<sup>3</sup> which directs the Secretary of HHS to consider actions to reduce nursing staff turnover, which is associated with negative impacts on safety and quality of care.<sup>4</sup> On September 6, 2023, we published the “Medicare and Medicaid programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting”<sup>5</sup> proposed rule (referred to as the “proposed rule”).

The safety and quality concerns identified by the President 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, among other things, a review of data collected since 2016 and lessons learned during the COVID–19 Public Health Emergency (PHE). Numerous studies, including a new research study commissioned by CMS as well as existing literature, have shown that staffing levels are closely correlated with the quality of care that LTC facility residents receive as well as with improved health outcomes. Higher staffing levels also provide staff in LTC facilities the support they need to safely care for residents. Minimum staffing standards can thus help prevent staff burnout, thereby reducing staff turnover, which can lead to more consistent care and improved safety and quality for residents and staff. This final rule also promotes 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 Provisions

We are updating the Federal “Requirements for Medicare and Medicaid Long Term Care Facilities” minimum staffing standards (“LTC requirements”). We will survey facilities for compliance with the updated LTC requirements in the rule and enforce them as part of CMS’s existing survey, certification, and enforcement process for LTC facilities. In addition, consistent with the President’s reform plan, we will display our determinations of

<sup>3</sup> E.O. 14095, 88 FR 24669 (Apr. 21, 2023).

<sup>4</sup> Zheng, Q, Williams, GS, 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.

<sup>5</sup> 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.

<sup>6</sup> 88 FR 61352 through 61429.

facility compliance with the minimum staffing standards on Care Compare<sup>7</sup> and require facilities to post a public notice within the facility if they are out of compliance with the standards so it is easily visible for staff and residents.

We are establishing 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 create a consistent floor to reduce variability in the minimum floor for nurse-to-resident ratios across States, the need to support nursing home staff, and, most importantly, to reduce the risk of residents receiving unsafe and low-quality care.

The regulatory updates are based on evidence we collected using a multifaceted approach, informed by multiple sources of information, including the 2022 Nursing Home Staffing Study; more than 3,000 public comment submissions from the Fiscal Year 2023 Skilled Nursing Facility Prospective Payment System proposed rule (FY2023 SNF PPS) request for information (RFI); academic and other literature; Payroll Based Journal (PBJ) System data; detailed listening sessions with residents and their families, workers, health care providers, and advocacy groups; and analyzing the 46,520 comments received on the proposed rule.

Specifically, in the final rule, we are revising § 483.35(b) to require an RN to be on site 24 hours per day and 7 days per week (24/7 RN) to provide skilled nursing care to all residents in accordance with resident care plans, with an exemption from 8 hours per day of the onsite RN requirement under certain circumstances. Requirements for this exemption are consistent with the requirements for other waivers and exemptions set forth in the LTC requirements. We are also adopting total nurse staffing and individual minimum nurse staffing 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). We are specifying that facilities must provide, at a minimum, 3.48 total nurse staffing hours per resident day (HPRD) of nursing care, with 0.55 RN HPRD and 2.45 NA HPRD. We are defining “hours per resident day” 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 CMS. We note that while the 3.48 total nurse staffing, 0.55 RN, and 2.45 NA 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 minimum 3.48 total nurse staffing, 0.55 RN, and 2.45 NA HPRD standards regardless of the individual facility’s resident case-mix, as they are the minimum standard of staffing. If the acuity needs of residents in a facility require a higher level of care, as the acuity needs in many facilities will, a higher total, RN, and NA staffing level will likely be required. As further described below, the minimum staffing standard is supported by literature evidence, analysis of staffing data and health outcomes, discussions with residents, staff, and industry<sup>8</sup> and other factors.

Each of the minimum staffing requirements independently supports resident health and safety and is evaluated separately. Therefore, compliance with the 24/7 RN requirement does not simultaneously constitute compliance with the minimum 3.48 HPRD total nurse staffing standard, the 0.55 RN HPRD, or the 2.45 NA HPRD requirements or vice versa. Similarly, but separately, a minimum number of total nurse staffing including RN and NA hours per resident per day improves overall quality of care. Both independently and collaboratively, these requirements and the totality of the LTC requirements for participation, will 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.

The resulting, evidence-based final rule appropriately prioritizes quality and safety of care gains from establishing minimum standards for nurse staffing, including RNs and NAs, with a particular emphasis on the direct care delivered at the bedside, and effective implementation of these new requirements. These new required minimum staffing requirements will increase staffing in more than 79 percent of nursing facilities nationwide,<sup>9</sup> and the specific RN and NA HPRD requirements exceed the existing minimum staffing requirements

in nearly all States.<sup>10</sup> We remain committed to continued examination of staffing thresholds, including careful work to review quality and safety data resulting from initial implementation of the final rule and robust public engagement. Should subsequent data indicate that additional increases to staffing minimums are warranted and feasible, we anticipate that we will revisit the minimum staffing standards to shift them toward the higher ranges supported by the evidence, with continued consideration of all relevant factors.

We are also revising the existing Facility Assessment requirements at § 483.70(e). We are redesignating the provisions at § 483.70(e) to a standalone section at § 483.71. We are further modifying the 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.

As we indicated in the proposed rule, we are finalizing a staggered implementation of these requirements over a period of up to 5 years for rural facilities and 3 years for non-rural facilities to allow all facilities the time needed to prepare and comply with the new requirements.

Exemption from the minimum standards of 0.55 HPRD for RNs, 2.45 HPRD for NAs and 3.48 HPRD for total nurse staffing, and the 8-hours per day of the 24/7 RN onsite requirement would be available only in limited circumstances. In order to qualify for an exemption, a facility must meet the following criteria: (1) the workforce is unavailable as measured by having a nursing workforce per labor category that is a minimum of 20 percent below the national average for the applicable nurse staffing type, as calculated by CMS, by using the Bureau of Labor Statistics and Census Bureau data;<sup>11</sup> (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; (4) the facility posts a notice of its exemption status in a prominent and publicly viewable location in each resident facility; and (5) the facility provides individual notice of its exemption status and the degree to

<sup>10</sup> Based on information in the staffing study report appendix E2 all States with the exception of 2 have a total staffing HPRD greater than 3.48 or for RN greater than .55HPRD (source: PBJ data Average 2022 Q1 nursing staffing levels by State).

<sup>11</sup> For example, *Hospital Review* at <https://www.beckershospitalreview.com/workforce/nurses-per-capita-ranked-by-state.html>.

<sup>7</sup> <https://www.medicare.gov/care-compare/?redirect=true&providerType=NursingHome>.

<sup>8</sup> 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>.

<sup>9</sup> PBJ data from the October 2021 Nursing Home Care Compare data set.

which it is not in compliance with the HPRD requirements to each current and prospective resident and sends a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. If the exemption is granted, CMS will post on Care Compare a notice of its exemption status and the degree to which it is not in compliance with the requirements.

A facility will be excluded from being eligible to receive an exemption if it: (1) has failed to submit PBJ data in accordance with re-designated § 483.70(p); (2) is a Special Focus Facility (SFF); (3) has 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; or (4) has 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. We note

that the existing statutory waiver for all RN hours over 40 hours per week will still be available as required by sections 1819(b)(4)(C)(ii) and 1919(b)(4)(C)(ii) of the Act, as this rule does not purport to eliminate or modify the existing statutory waiver.

As with other LTC requirements for participation, enforcement actions, also called remedies, may be taken against facilities that are not in substantial compliance with these Federal participation requirements under 42 CFR part 488, subpart F. The remedies that may be imposed include, but are not limited to, the termination of the provider agreement, denial of payment for new admissions, and/or civil money penalties.

We also proposed, and are finalizing, new regulations at 42 CFR 442.43 (with a cross-reference at 42 CFR 438.72) to 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 (ICFs/IID) that are spent on compensation for direct care workers and support staff. This requirement 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. In addition, the requirements being finalized in this final rule are consistent with efforts to address the sufficiency of payments for home and community-based services (HCBS) to direct care workers and access to and the quality of services received by beneficiaries of HCBS finalized in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**. As finalized, States will have to comply with these requirements beginning 4 years from the effective date of this final rule.

*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 3.48 total nurse staffing, 0.55 RN, and 2.45 NA HPRD requirements), which includes staggered implementation of the requirements, would result in an estimated cost of approximately \$53 million in year 1; \$1.43 billion in year 2; \$4.4 billion in year 3; with costs increasing to \$5.8 billion by year 10. We estimate the total cost over 10 years will be \$43 billion, which was derived from <i>FY 2021 Worksheet S-3, Part V</i> of the Medicare Cost Report. LTC facilities are responsible for these costs. 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, increased safety and quality of care for LTC residents as well. Lack of quantification is also noteworthy as regards key categories of costs.
Medicaid Institutional Payment Transparency Reporting	The overall total economic impact for the reporting requirements is a one-time cost of \$37.6 million and ongoing annual costs of \$18.3 million per year. We estimate a 10-year cost of \$147.9 million.  The burden will be shared among States, the Federal Government, and Medicaid-certified nursing facilities and ICFs/IID as follows: <ul style="list-style-type: none"> <li>• States: \$540,000 one-time costs, \$200,000 ongoing annual costs</li> <li>• Federal Government: \$540,000 one-time costs, \$200,000 ongoing annual costs</li> <li>• Nursing facilities and ICFs/IID: \$36.6 million one-time costs, \$17.9 million annual ongoing costs.</li> </ul>

## 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 permits 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<sup>12</sup> 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 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. In order to be certified to participate in Medicare and Medicaid programs, prospective and existing providers of services must meet and continue to meet all applicable Federal participation requirements. These Federal participation requirements are the basis for survey activities in LTC facilities for ensuring that residents' minimum health and safety requirements are met and maintained, as well as for facilities 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 (SNF/NF) 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 that 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.<sup>13</sup>

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".

#### 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. As part of this 2016 final rule, we revised the LTC 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. Prior to issuing this final rule, in August 2015 we mandated the requirement for LTC facilities to submit direct care staffing information based on payroll data to CMS as part of the "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection final rule" (80 FR 46390).<sup>14</sup> In the 2015 Reform of Requirements for Long-Term Care Facilities 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). Since

<sup>12</sup> 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.

<sup>13</sup> <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483#483.70>.

<sup>14</sup> Medicare Program; SNF PPS FY 2016 Final Rule. <https://www.federalregister.gov/documents/2015/08/04/2015-18950/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>.

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, which was unavailable at the time, and new evidence from the literature.

Additionally, as a part of the FY 2023 Skilled Nursing Facility Prospective Payment System Proposed Rule Request for Information (FY 2023 SNF PPS RFI) commenters provided examples of ongoing quality and safety concerns within LTC facilities.<sup>15</sup> These included, but were not limited to, residents going entire shifts without receiving toileting or multiple 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<sup>16</sup> corroborated these comments and identified that basic care tasks, such as bathing, toileting, and mobility assistance, are often delayed when LTC facilities are understaffed, which is not sufficient to meet the nursing needs of residents. 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. We refer readers to the proposed rule for a detailed discussion of the concerns highlighted in interviews as part of the 2022 Staffing Study (88 FR 61359).<sup>17</sup>

The academic literature also suggests the importance of adequate staffing in LTC facilities. In a 2021 study, where interview data were examined, and multivariate analyses of resident outcomes were conducted, the 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 a decreased number of outpatient emergency department

visits.<sup>18</sup> 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 nursing homes that had higher licensed nurse staffing levels had better end-of-life care and were less likely to experience potentially avoidable hospitalizations.<sup>19</sup>

The COVID-19 Public Health Emergency (PHE) further highlighted and exacerbated long-standing concerns about inadequate staffing in LTC facilities. The COVID-19 PHE also yielded evidence that appropriate staffing made a difference as a part of the overall response in LTC facilities. 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 more stars for nurse staffing in the Five Star Quality Rating System than in counterpart facilities with a rating of one to three stars for staffing.<sup>20</sup> 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 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.<sup>21</sup> 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 also contributed to understaffing, nurse burnout, and position turnover.<sup>22</sup> 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. 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 for a variety of reasons including the difficulty of the work and comparatively lower pay, although it has steadily increased over the past year and a half.<sup>23 24</sup> There is also evidence that facilities have additional funding that they could be devoting to staffing. For example, one paper found that nursing homes in Illinois were much more profitable than claimed but that 63 percent of those profits were hidden and directed to related parties of the owner. If those hidden profits were instead put toward staffing, the study found, RN staffing could be substantially increased and the share of facilities in compliance with the registered nurse requirements of the proposed rule would rise by twenty percentage points from 55.2 percent to 75.6 percent and compliance with the nurse aide HRPD requirement would rise from 15.3 percent to 36.1 percent in Illinois.<sup>25</sup>

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) highlight the need for national minimum staffing standards for direct care in LTC facilities.

10.1016/j.outlook.2020.06.008. Epub 2020 Oct 4. PMID: 33023759; PMCID: PMC7532952.

<sup>23</sup> Refer, for example, to a report from the Kaiser Family Foundation indicating that as of March 20, 2022, 28 percent 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>.

<sup>24</sup> [https://data.bls.gov/timeseries/CES6562300001?amp%253bdata\\_tool=VGTable&output\\_view=data&include\\_graphs=true](https://data.bls.gov/timeseries/CES6562300001?amp%253bdata_tool=VGTable&output_view=data&include_graphs=true).

<sup>25</sup> Ashvin Gandhi and Andrew Olsenski, Tunneling and Hidden Profits in Health Care, NBER Working Paper (March 2024), Tunneling and Hidden Profits in Health Care (nber.org).

<sup>15</sup> 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. 87 FR 22720, April 15, 2022 (<https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>).

<sup>16</sup> 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>.

<sup>17</sup> <https://www.federalregister.gov/documents/2023/09/06/2023-18781/medicare-and-medicaid-programs-minimum-staffing-standards-for-long-term-care-facilities-and-medicaid>.

<sup>18</sup> 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.

<sup>19</sup> 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>.

<sup>20</sup> Figueroa JF, Wadhwa 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.

<sup>21</sup> <https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16689>.

<sup>22</sup> 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:

Chronic understaffing nonetheless continues in LTC facilities, and evidence demonstrates the benefits of increased nurse staffing in these facilities. For example, a report by the HHS 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.<sup>26</sup> The literature also 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. In particular, there has been evidence of new for-profit owners reducing levels of registered nurse staffing in order to reduce costs.<sup>27</sup>

Finally, multiple studies have shown that nursing home quality is generally lower in LTC facilities that serve high proportions of minority residents.<sup>28 29 30</sup> 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.<sup>31 32</sup> Furthermore, disparities in safety and quality of care exist between LTC facilities with a high number of Medicaid residents and LTC facilities that have a high number of Medicare residents, with facilities with a high number of Medicaid residents tending to have worse outcomes.<sup>33</sup> These disparities can contribute to differences in quality across facilities' sites.<sup>34</sup> 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, will help to advance equitable, safe, and quality care sufficient to meet the nursing needs for all residents and greater consistency across facilities.

<sup>26</sup> Office of Inspector General (OIG), *Some Nursing Homes' Reported Staffing Levels in 2018 Raise Concerns; Consumer Transparency Could Be Increased*, OIG-04-18-00450, August 2020. <https://oig.hhs.gov/oei/reports/oei-04-18-00450.asp>.

<sup>27</sup> [https://www.nber.org/system/files/working\\_papers/w28474/w28474.pdf](https://www.nber.org/system/files/working_papers/w28474/w28474.pdf).

<sup>28</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805666/>.

<sup>29</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108174/>.

<sup>30</sup> <https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.12079>.

<sup>31</sup> [https://www.jamda.com/article/S1525-8610\(21\)00243-7/fulltext](https://www.jamda.com/article/S1525-8610(21)00243-7/fulltext).

<sup>32</sup> <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0094>.

<sup>33</sup> 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.

<sup>34</sup> <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0094>.

### 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 was to establish a minimum nursing home staffing requirement for LTC facilities participating in Medicare and Medicaid.<sup>35</sup> 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 FY 2023 SNF PPS RFI,<sup>36</sup> 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 would affect other CMS programs and/or initiatives as well as the enforceability of such standards.

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, providers and provider industry associations, labor unions and organizations, nursing home residents, staff and administrators, industry experts, researchers, family members, and caregivers of residents in LTC facilities.

In the proposed rule we discussed the 2022 nursing home staffing study<sup>37</sup> that

<sup>35</sup> <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/>.

<sup>36</sup> 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. <https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>.

<sup>37</sup> 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>.

CMS commissioned (see 88 FR 61359-61364). In brief, the key takeaways were:

- There is no clear, consistent, and universal methodology for setting specific minimum staffing standards, as evidenced by the varying current standards across the 38 States and the District of Columbia that have adopted their own staffing standards.

- The relationship between staffing and quality of care and safety, varies by staff type and level as follows:

- ++ Total Nurse Staffing hours per resident day of 3.30 or more have a strong association with safety and quality care.

- ++ 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 appear to have any consistent association with safety and quality of care.

However, we recognize that LPN/LVN professionals undoubtedly provide important services to LTC facility residents despite the findings that LPN/LVN staffing levels do not appear to have a consistent association with safety and quality of care, unlike RN and NA staffing levels.

- Increasing nursing staffing levels are associated with benefits including enhanced safety and quality, as well as costs, namely financial costs to LTC facilities.

In addition to commissioning the 2022 Nursing Home Staffing Study and issuing the FY 2023 SNF PPS RFI, CMS 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. We described the general content of these listening sessions in the 2023 proposed rule (see 88 FR 61352).

### 4. Ongoing CMS Initiatives and Programs Impacting LTC Facilities

In establishing the proposed and final minimum staffing standards, we also considered ongoing CMS policies, programs, and operations, including the SNF Prospective Payment System (SNF PPS), 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. Medicare Skilled Nursing Facility Prospective Payment System

The Medicare SNF PPS 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) that is statutorily required to be updated annually. The FY 2025 SNF PPS proposed rule published on April 3, 2024, and proposed to update the Medicare payment policies and rates for SNFs for FY 2025. For the proposed FY 2025 update, CMS estimated that the aggregate impact of the payment policies in the proposed rule would result in a net increase of 4.1 percent, or approximately \$1.3 billion, in Medicare Part A payments to SNFs in FY 2025, if finalized. 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 prices. Specifics regarding the process to update SNF PPS payment rates are discussed in the rule.<sup>38</sup>

#### b. 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 to improve quality of care provided to residents.<sup>39</sup> Performance on the Total Nurse Staffing measure in FY 2024 will be used to make payment adjustments 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 minimum staffing standards are not duplicative of this existing measure; rather, they are complementary by establishing a consistent and broadly applicable national floor (baseline) 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.

<sup>38</sup> 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 2025. <https://www.cms.gov/newsroom/fact-sheets/fy-25-skilled-nursing-facility-prospective-payment-system-proposed-rule-cms-1802-p>.

<sup>39</sup> <https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2023-skilled-nursing-facility-prospective-payment-system-final-rule-cms-1765-f>.

#### c. Nursing Home Survey and Enforcement

The LTC minimum staffing standards in this regulation are part of the Federal participation requirements for LTC facilities which 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 processes under 42 CFR part 488.<sup>40</sup> Section 1864(a) of the Act authorizes the Secretary to enter into agreements with the State survey agencies to determine whether SNFs meet the Federal participation requirements for Medicare. Section 1902(a)(33)(b) of the Act provides for the State survey agencies to perform the same survey tasks for NFs in Medicaid. The results of these surveys are used by CMS and the State Medicaid Agency, respectively, as a basis for a decision to enter into, deny, or terminate a provider agreement with the facility. They are also used to determine whether one or more enforcement remedies should be imposed against LTC facilities that are not in substantial compliance with these Federal participation requirements. 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 substantial 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 to a facility, for Medicare, or to a State, for Medicaid;
- 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

<sup>40</sup> <https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertification/enforcement/nursing-home-enforcement>.

seriousness, that is, 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 Medicare and Medicaid LTC facilities on the CMS public-facing Care Compare website, including the number of certified beds and a facility's overall Five Star quality rating, including three individual star ratings in the categories of inspections, staffing, and quality measurement.<sup>41</sup> In addition, individual performance quality measures are included on Care Compare. With respect to nursing home 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 (health inspection data), reporting through the PBJ System, and resident assessment data reported by LTC facilities to us.

Over the last several years, CMS has taken a number of actions to strengthen our oversight and enforcement of compliance. For example, in 2022, CMS began integrating PBJ data into the survey process to help target surveyors' investigations of a facility's compliance; in 2023, CMS announced it would undertake new analyses of State inspection findings to ensure cited deficiencies receive the appropriate consequence, particularly involving resident harm.<sup>42</sup> Additionally, we began posting levels of weekend staffing and rates of staff turnover, and using these metrics in the Five Star Quality Rating System to help provide more useful information to consumers. Furthermore, CMS revised the policies in the Special Focus Facility (SFF) program to ensure these facilities make sustainable improvements to protect residents' health and safety.<sup>43</sup> In January 2023, CMS began conducting audits of

<sup>41</sup> 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>.

<sup>42</sup> <https://www.whitehouse.gov/briefing-room/statements-releases/2023/09/01/fact-sheet-biden-harris-administration-takes-steps-to-crack-down-on-nursing-homes-that-endanger-resident-safety/>.

<sup>43</sup> <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-strengthens-oversight-nations-poorest-performing-nursing-homes>.

facilities' medical records to identify if residents were inappropriately given a diagnosis of schizophrenia, and administered antipsychotics drugs, which are very dangerous for residents. Lastly, in November 2023, CMS released a final rule that implemented portions of section 6101 of the Affordable Care Act, requiring the disclosure of certain ownership, managerial, and other information regarding LTC facilities.<sup>44</sup>

As noted previously in this section, we have been moving towards more data-driven enforcement, including use of the PBJ System data to guide monitoring, surveys and enforcement of existing staffing requirements. Additionally, starting in late 2023, CMS expanded audits of these data. We continue to recognize, however, 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. Often, that will require higher staffing than the minimum requirements. The additional requirements 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 (baseline).

In summary, the benefits and success of minimum staffing standards are heavily dependent on our utilization of the survey and enforcement 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.

#### d. 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 Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register** and Medicaid and CHIP Managed Care Access, Finance, and Quality final rule published elsewhere in this **Federal Register**, we finalized several policies that will work alongside those included in this rule. These finalized 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 certain Medicaid HCBS providers' 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.<sup>45</sup>

Notably, similar to the findings in the 2022 Nursing Home Staffing Study, we believe that the minimum staffing standards finalized in this rule will improve quality of care which includes facilitating the transition of care to community-based care services and potential Medicare savings.

#### B. Provisions of the Proposed Regulations and Analysis and Response to Public Comments

In response to the proposed rule, we received 46,520 total comments. Commenters included long term care consumers, advocacy groups for long-term care consumers, organizations representing providers of long-term care and senior service, long-term care ombudsmen, State survey agencies, various health care associations, legal organizations, labor unions, residents, families, and many individual health care professionals (such as nursing organizations) and administrative staff. 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. Most commenters supported the proposed rule's goals to ensure safe and quality care in LTC facilities.

In this final rule, we provide a summary of each proposed provision, a summary of the public comments received and our responses to them, and an explanation for changes in the policies that we are finalizing.

#### 1. General Comments

*Comment:* Many commenters shared their personal stories of care provided and received in nursing homes. While a majority of these commenters shared observations of the compassion shown by well-meaning staff, they also shared observations of missed care and avoidable harm that occurred due to insufficient staffing. A resident stated:

- "I was in a nursing home for rehab on discharge from hospital the day after I broke my shoulder in a fall down a staircase. When a fire alarm sounded I was on the toilet. I heard the automatic fire doors close. I stayed as calm as I could, reminding myself someone would come to get me off the toilet and out to safety. Half an hour later activity resumed nearby and a CNA did help me off the toilet. She said 'Oh I wasn't worried about you, I knew you'd get yourself out through the window if you needed to.'"

Many family members and friends shared personal stories, urging CMS to adopt minimum staffing standards to prevent future incidences like the ones that their loved ones experienced. Families and friends wrote:

- "She was a successful Real-estate broker her whole adult life, who suffered a tragic fall that left her with multiple breaks in her leg and landed her in a nursing home for rehab. What she lost in the nursing home was far greater than the break, she lost her dignity and self-worth as she was forced to lay in her own urine on a regular basis and on several occasion her own feces. The staff were caring and capable but there was never enough of them."

- "The major concern was the stage 4 bed sores that Jerry developed after 6 weeks at BNR while Jerry was under their care. Jerry was continually left sitting in his own feces as he was both urinary and bowel incontinent. He was unable to get help or attention on numerous occasions by pressing the call button, to the point of purchasing a bull

<sup>44</sup> <https://www.cms.gov/newsroom/fact-sheets/disclosures-ownership-and-additional-disclosable-parties-information-skilled-nursing-facilities-and-0>.

<sup>45</sup> Money Follows the Person | Medicaid, <https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html>.



horn with a siren to summon help, of course this didn't improve matters. Several times his roommate would be unconscious and hanging out of his bed a hairs breadth away from falling with no belts or restraints, which I personally witnessed and alerted an aide who replied 'he likes it that way'.

- "I had a loved one recently fall in a Memory Care Facility. She was on the floor for quite some time before she was discovered. She had a broken hip and no ability to become ambulatory. All she had done was attempt to go to the bathroom in the middle of the night. My recommendation is that a patient should not be left to get themselves to the bathroom alone in the night. Why can't they have enough staff on hand that they can provide someone to help each patient to the bathroom and safely return to bed?"

- "This past year my partner spent several months in a nursing home/rehab facility and I personally saw how shorthanded they were. The lack of adequate staff, number of part-time and substitute staffing, poor pay, was obvious. The nights were the worse time. A patient could ring for help and wait and wait an hour for a response. They could ask for a glass of water and wait hours for it to come. They could lay in their own waste or urine-soaked bedding for way too long, day or night. Those who needed help being fed would often just have the food delivered and if a family member wasn't there to help them eat they would go hungry."

- "They were supposed to check in on him every hour and to help him turn from side to side at least every two hours. Later, when he got better, they were supposed to check on him every four hours, but they didn't. They were supposed to change his clothing and bedsheets regularly. They did none of that often enough, so he developed bedsores/open wounds as big as your hand on his backside because of a lack of care. How would you like your dad to go through that experience in the last 24 months of his life, after all he'd been through in 90 years?"

- "In June 2021 while the day shift nurse was making morning rounds she found my family member aspirating on vomit, having seizures, with a 106 degree temperature which turned in to a case of sepsis. The nurse said she had no idea how long my family member was lying there in that condition as there was only 1 nurse and 1 aide for over 100 residents on the overnight shift. Since that incident my family member has lost the ability to speak and/or respond to questions and or commands. As a result I have personally spent 10 to 12 hours a day, every day,

with my family member at the LTC to ensure they are getting the care they need."

- "My loved one was basically starved to death—all dementia patients in that specific ward were, due to not enough staff helping them eat. Two people were on staff to help 20 patients, so only the three catatonic people got help. Other patients would be distracted, which is natural, at meals, but then weren't encouraged to eat, due to lack of sufficient staff. The patients would therefore lose weight weekly and be dizzy, malnourished weak, leading to frequent falls and more and more bedridden patients. These patients would then get pneumonia and die. There were never enough staff to clean up spills and urine fast enough- I visited frequently and witnessed fall after fall constantly around me due to this problem. There were never enough staff to do ANYthing."

Likewise, many nursing home staff wrote of their own experiences and observations while trying to safely deliver care to residents. Staff wrote:

- "Personal observations from my nursing home consulting work as a Registered Dietitian: Nurses so short staffed they declare a 'med holiday' and throw away all the meds for one shift because they don't have time to pass them out. Nursing so understaffed that bedtime snacks, though made and delivered to the nursing station, are not passed out. Resulting in one insulin dependent diabetic resident's blood sugar zeroing out in the wee hours of the night. Patient died."

- "Recently a resident got skin ulcers after no one was able to see him for the entire 8-hour shift, and who knows how long before that? When you have 14 or 18 or 20 residents to care for, there's simply not enough time for everyone. Feeding them all takes so much time, several hours combined right there. That's how other basic needs fall by the wayside. When you're doing the job of two CNAs, it really means that half of your residents are going to have to go without."

- "Last week, after two aides did not show up for their shift, it led to several residents missing their breakfast. That's just one example unfortunately, residents regularly miss meals or have to eat them late. The problem is that whenever staff is needed for one urgent task, were usually in the middle of another urgent task that cannot be interrupted."

- "Residents in our facility are recovering from surgery or things like strokes and they need a lot of help. With how many residents I am caring for, I don't have time to give them the best

care. I feel like I'm always rushing to the next person, and they get upset, and this is not good for their recovery. If they have to go to the bathroom and can't wait, they try to go by themselves and they end up falling."

*Response:* We thank commenters for sharing their personal stories. The compelling narratives shared by commenters demonstrate the dangers of inadequate staffing in nursing homes, not as an impersonal set of numbers and percentages, but as the lived experiences of the more than 1 million people receiving nursing home services each year. As evidenced by the thousands of personal stories told in the comments, there is a persistent, pervasive problem in the safety of nursing home care across the country that must be addressed. This final rule includes policies that will advance resident safety, and we are committed to using all available CMS authorities to continue protecting residents now and in the future.

*Comment:* Comments on the proposed rule varied in level of support and opposition. Many commenters expressed overall support for the proposed revisions to the regulations and concern about the health and safety of nursing home residents. Numerous commenters encouraged CMS to further strengthen the requirements and not finalize the version of the rule as proposed. A large number of commenters applauded CMS for taking a first step toward improvements for staff and residents in LTC facilities and noted additional opportunities to address workforce challenges. Many NAs and family representatives described the negative impact of low staffing levels on meeting residents' needs, writing of situations that ranged from residents that needed assistance with meals not getting that assistance and losing weight, to accounts of residents that had to stay in bed all weekend because the facility was short staffed. Many comments centered on unnecessary falls that occur because no one is around to assist residents to and from the bathroom. For example, one commenter who described themselves as a family member of many residents shared a personal description of their experience with a nursing facility, noting that their loved ones often share that "they have been waiting for hours just to go to the bathroom." Commenters noted that most LTC direct staff are doing the best they can and that increasing staff will decrease burnout, make their jobs safer, and lessen the potential for resident's safety events such as falls and pressure ulcers. For example, one NA with over 22 years of

experience highlighted that while they love their jobs, it has been one the hardest they ever held and having “Federal guidelines in place could help the elderly and their families feel more confident in the facilities.” This commenter also indicated that having Federal guidelines in place will provide individuals “more of an incentive to work in a long-term care facility.”

In contrast, other commenters expressed a desire to rescind the proposed rule, citing overall concerns about the financial burden and workforce shortages, training challenges, administrative burden, and limited housing options in sparsely populated areas for new staff.

*Response:* The large volume of comments that we received demonstrates the interest in resident health and safety issues. Numerous comments from residents, families, staff, and ombudsmen make it clear that there is a widespread lack of sufficient care by nursing staff in our nation’s LTC facilities. These comments provide further evidence of and support for our view that we will significantly improve resident safety through the establishment of minimum staffing requirements. The changes that we discuss in this final rule are intended to promote resident health, safety, and access to care.

We acknowledge the workforce challenges in LTC facilities. According to the Bureau of Labor Statistics (BLS), in March 2020, there were 3,372,000 staff working in nursing homes and other LTC facilities and an average of 1,319,318 residents per day in nursing homes. Total staffing dropped to a low of 2,961,200 for staff working in nursing homes and other LTC facilities in January 2022, a decrease of approximately 410,000 staff from March 2020. The daily census of residents averaged 1,152,842 per day in nursing homes in January 2022. Workforce challenges may have contributed to the drop in staff, but it appears to have been caused by multiple factors, such as the drop in the number of nursing home residents. The number of staff is improving, as of November 2023 there are 3,216,700 staff working in nursing homes and other LTC facilities, still 155,300 less than March 2020. Facilities averaged 1,201,585 residents per day in November 2023. Please note, this data is for all employees in these facilities, not just healthcare staff.<sup>46</sup> As stated in the proposed rule, it is the policy of the

<sup>46</sup> Bureau of Labor Statistics. [https://data.bls.gov/timeseries/CES6562300001?amp%253bdata\\_tool=XGtable&output\\_view=data&include\\_graphs=true](https://data.bls.gov/timeseries/CES6562300001?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true). Accessed 02/28/24.

Biden-Harris Administration to ensure that the LTC workforce is supported, valued, and well-paid.<sup>47</sup>

We note the efforts that many commenters described regarding their recruitment, hiring and training of employees along with retention efforts for existing employees. We support the concept of implementing workforce development programs, as they benefit not only the employees but ultimately the residents. CMS is launching a comprehensive workforce development initiative<sup>48</sup> and is also exploring the potential to provide technical assistance to LTC facilities through the existing Quality Improvement Organizations. While the requirements of this rule are intended to improve resident safety and care, they may also improve the working environment in LTC facilities. Establishing staffing minimums will assure that NAs, for example, have enough nursing staff present in the facility for a safe 2-person resident transfer using a mechanical lift, reducing resident and staff injuries, as well as staff burnout. The new requirement that facilities must involve their direct care workers and their representatives in the facility assessment allows the staff to provide meaningful input regarding the facility’s operations, which has the potential to lead to a better working environment that complements retention and hiring efforts. In addition, having a 24/7 RN presence can improve resident safety<sup>49</sup> with the added benefit of providing more professional support to all facility workers.

*Comment:* Some commenters stated that the pool of former nursing home workers who left the sector is more than sufficient to cover the demand for new workers, while numerous commenters voiced questions about the availability of workforce and whether this is the right time to implement staffing minimums. A few commenters denied the existence of a staffing shortage. One

<sup>47</sup> 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 March 19, 2023.

<sup>48</sup> FACT SHEET: Biden-Harris Administration Takes Steps to Crack Down on Nursing Homes that Endanger Resident Safety | The White House: <https://www.whitehouse.gov/briefing-room/statements-releases/2023/09/01/fact-sheet-biden-harris-administration-takes-steps-to-crack-down-on-nursing-homes-that-endanger-resident-safety/>.

<sup>49</sup> 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>.

commenter stated it was a pay shortage and that challenges with a lack of qualified staff would be readily resolved by higher pay and better working conditions. Some commenters explained that the LTC workforce has not recovered from the impact of the COVID PHE. Some commenters noted that LTC facilities were already having issues hiring sufficient staff due to the lack of qualified, available staff in their area. For example, one commenter pointed out that in the State of Missouri, less than 4 percent of RNs were looking for work and that more than a quarter of RNs were 54 or older, suggesting that not only were there few RNs looking for work but also a significant number would likely be retiring in the next several years.<sup>50</sup> The commenter noted that compliance with these minimum staffing requirements would require hundreds of new RNs. Some commenters asked where these additional RNs would come from to staff LTC facilities. Some commenters shared concern about shortages of RNs overall and specifically the scarcity of RNs who chose to work in LTC facilities. They stated this needs to be recognized as an impediment to some facilities being able to meet staffing minimums. A commenter expressed concerns that due to the minimum staffing requirements, providers will likely encounter heightened levels of competition in each labor market for RNs and NAs. Moreover, the commenter stated that it would be even more challenging to recruit and retain staff for “smaller LTC facilities and those located in rural areas than larger, better-funded facilities in nearby urban areas”. Some recommended that this minimum staffing standards regulation be suspended until there were enough RNs to staff LTC facilities to comply with the 24/7 RN and 0.55 RN HPRD requirements. Other commenters stated that their facilities have been trying to hire nursing staff without success and that they rely on staffing agencies, a process which offers its own set of unique challenges for facilities.

*Response:* We acknowledge that there are workforce challenges in various areas of the country. CMS is committing over \$75 million to launch an initiative to help increase the long-term care workforce.<sup>51</sup> We expect that these funds

<sup>50</sup> Missouri State Board of Nursing. (2022). 2022 Missouri Nursing Workforce Report. Jefferson City, MO: Missouri State Board of Nursing. <https://pr.mo.gov/boards/nursing/2022%20Missouri%20Nursing%20Workforce%20Report.pdf>.

<sup>51</sup> FACT SHEET: Biden-Harris Administration Takes Steps to Crack Down on Nursing Homes that Endanger Resident Safety | The White House:

will be allocated for such purposes as for tuition reimbursement, we are also exploring the potential to provide additional technical assistance to LTC facilities through the Quality Improvement Organizations. The Department of Labor and other parts of the Biden-Harris Administration are also investing in building a strong nursing workforce and expanding the pipeline of new staff. In response to comments, and in addition to the \$75 million workforce development investment and potential technical assistance, we have made some changes to the proposed minimum staffing standards requirements to provide additional flexibility and time for facilities to implement these changes while maintaining safety and quality. The final requirements have staggered implementation dates over a period of up to five years. A total nurse staffing standard has been added and there are exemptions from the minimum staffing standards. We will continue to examine resident safety issues and potential changes going forward. The minimum staffing standards will provide staff in LTC facilities the support they need to safely care for residents, and help prevent staff burnout, thereby reducing staff turnover, which can lead to improved safety.

*Comment:* Numerous commenters voiced support for the proposed regulations but asked for funding, indicating that the financial implication of hiring staff to meet the standards was a roadblock. Commenters stated that the implementation of the minimum nursing staffing requirement will bring increased costs, and in the absence of reimbursement for these costs, the LTC facilities will have to absorb those increased costs, causing financial strain. One commenter recommended increasing payment rates using wage pass through rules. Some commenters stated that nursing homes cannot compete with hospitals for RN salaries. Other commenters expressed concern that unintended consequences of hiring more staff would result in higher fees for residents and their families. In contrast, other commenters suggested that nursing homes have the financial means to provide quality staffing, without additional funding. Some of these commenters highlighted the profits earned by nursing homes, which make them a desirable investment opportunity, as well as diversion of

funds to related-party expenses or excess administrative costs.<sup>52</sup>

*Response:* While funding, salaries paid by other healthcare providers, and fees that residents are charged are outside the scope of this rulemaking, we crafted the rule with careful consideration that the majority of LTC facilities will need to recruit, hire, and train new staff. In the proposed rule we noted that non-profit nursing homes were three times more likely to already be in compliance with the proposed minimum staffing requirements suggesting a relationship between profit model and staffing.<sup>53</sup> Through phased-in implementation facilities may not have to hire all the necessary nursing staff at one time. There are also waivers and hardship exemptions available to LTC facilities on a case-by-case basis. Please see sections II B.4, “Registered Nurse 24 hours per day 7 days per week,” and II B.5, “Hardship Exemption from Minimum Hours per Resident Day and RN onsite 24 hours per day 7 days per week,” of this rule for more details. In addition, please see section VI, “Regulatory Impact Analysis,” for estimates of expenditures related to this final rule.

*Comment:* A commenter noted that LTC facilities must meet State and Federal requirements for health and safety. Some commenters were concerned about the burden of meeting both their State requirements and Federal requirements. A commenter expressed concern about conflicts between State and Federal staffing requirements. The commenter suggested rewards for facilities located in States that have higher staffing standards and reimbursement cuts for facilities located in States that have reduced or eliminated staffing standards compared to Federal minimum staffing standards.

*Response:* Complying with State and Federal requirements is not new to LTC facilities. Generally, healthcare facilities in the United States function under State and Federal regulations. With regard to the updates to the requirements for Medicare and Medicaid participation for LTC facilities, the provisions in this final rule are not intended to and would not preempt the applicability of any State or local law providing a higher standard. In States where there is a higher HPRD requirement for RNs or NAs, or an RN coverage requirement in excess of at

least one RN on site 24-hours per day, 7 days a week, or a total nurse staffing minimum above 3.48 HPRD that is required by this final rule, or any other specific requirement such as for LPNs/LVNs, the facility would be expected by its State or local government to meet the higher standard. 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 or local law. Facilities in states that have eliminated their staffing standards are required to comply with Federal law. We are not aware of any State or local law providing for a maximum staffing level. This final 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 finalized in this rule or from meeting higher staffing levels required based on the facility assessment provisions finalized in this rule. Financial adjustments related to State staffing requirements are outside the scope of this rule.

*Comment:* Numerous commenters described various issues involving nursing education and the volume of new nurse graduates. Some commenters suggested investing in nursing school infrastructure. Another commenter recommended a policy that includes educational opportunities for individuals to enter nursing and other health care fields, increasing the number of nursing educators, and subsidies for NA training programs. One commenter asked that CMS offer student loan forgiveness, or no-interest student loans for those entering the nursing profession. Some commenters stated that the proposed \$75 million workforce campaign that will be coordinated by CMS and was announced in tandem with the proposed rule, is not sufficient to train the additional nursing staff that are needed. Other commenters asked that CMS work to ensure funding for training and recruiting qualified staff that includes home health and hospice providers. Another commenter asked CMS to work on recruitment and retention of LTC facility nursing staff. Other commenters expressed concern that the \$75 million workforce campaign funds should not be used to train surveyors who will eventually

<sup>52</sup> Comments of the Long Term Care Community Coalition at 10–11.

<sup>53</sup> 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>.

assess enforcement actions against nursing homes.

*Response:* We agree that educating and training new nursing staff is important for the nursing home workforce. On September 1, 2023, the White House published a fact sheet detailing various initiatives that promote safety in LTC facilities.<sup>54</sup> One of the initiatives is focused on growing the nursing workforce. CMS is launching a new nursing home staffing campaign to help workers pursue careers in nursing homes. This campaign will support the recruitment, training, and retention of nursing home workers, including the CMS investment of over \$75 million in financial incentives for nurses to work in nursing homes, through the Civil Money Penalty (CMP) Reinvestment Program. Other parts of the Federal Government are also investing in the nursing workforce. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides training and technical assistance to nursing facility staff serving individuals with serious mental illness and/or substance use disorders through its Center of Excellence for Building Capacity in Nursing Facilities to Care for Residents with Behavioral Health Conditions. The Department of Labor also provided \$80 million in grants last year as part of its Nursing Expansion Grant program to increase clinical and vocational nursing instructors and educators in the U.S., and train healthcare professionals, including direct care workers. The Health Resources and Services Administration (HRSA) has also administered other programs to increase the number of nurse preceptors, an example of a HRSA program that supports the training of clinical nurse preceptors is the Nurse Education, Practice, Quality and Retention-Clinical Faculty and Preceptor Academies (NEPQR-CFPA) Program.<sup>55</sup> Another nurse education program administered by HRSA is the FY 2023 Nurse Education, Practice, Quality and Retention (NEPQR)-Pathway to Registered Nurse Program (PRNP) Awards, this program creates a pathway for LPNs and LVNs to become RNs.<sup>56</sup>

<sup>54</sup> FACT SHEET: Biden-Harris Administration Takes Steps to Crack Down on Nursing Homes that Endanger Resident Safety | The White House: <https://www.whitehouse.gov/briefing-room/statements-releases/2023/09/01/fact-sheet-biden-harris-administration-takes-steps-to-crack-down-on-nursing-homes-that-endanger-resident-safety/>.

<sup>55</sup> Nurse Education, Practice, Quality and Retention-Clinical Faculty and Preceptor Academies (NEPQR-CFPA) Program | HRSA.

<sup>56</sup> FY 2023 Nurse Education, Practice, Quality and Retention (NEPQR)-Pathway to Registered Nurse

While the comments received on the specific details of the CMS nursing home staffing campaign are outside the scope of this rule, we acknowledge that workforce development is a shared responsibility, and encourage LTC facilities to partner with education and training sources to meet their staffing needs. We are also exploring the potential to provide additional technical assistance to LTC facilities through the Quality Improvement Organizations. We appreciate the information regarding nursing education, the number of new graduates and the suggestion to invest in nursing school infrastructure; however, these issues are not within the scope of CMS authority and this final rule. Likewise, the request for training and recruiting home health and hospice providers is also outside the scope of this rule. The request for student loan considerations is also outside the scope of this rule.

*Comment:* Several commenters suggested that CMS should work to promote an immigration policy that supports nursing staff to enter the United States and the nursing home workforce. Another commenter suggested building a domestic and international pipeline for potential nursing home workers to be recruited and trained.

*Response:* We appreciate these comments regarding the relationship between staffing and immigration policy. However, immigration policy is not within the scope of CMS authority.

*Comment:* One commenter stated that CMS should revisit the standards, at minimum, within one to two years of full implementation to determine if the agency's approach is yielding its intended outcomes and assess their impact on quality, safety, and access, followed by periodic reevaluations and redeterminations.

*Response:* We agree that it is important to review the impact that this final rule has on the delivery of care and services in LTC facilities. We also intend to monitor emerging research in this area to further inform our policy decisions. CMS continually reviews existing regulations to assess their appropriateness, effectiveness, and continued necessity. We intend to monitor LTC facility services, as well as the safety and quality of resident care, through the survey process, quality measure performance, and PBJ data to assess the impact of these new requirements and determine what, if any, future actions should be taken to assure that all residents receive safe care

Program (PRNP) Awards | Bureau of Health Workforce ([hrsa.gov](https://www.hrsa.gov)).

at all times and that their needs are met. We realize that standards of care are constantly evolving and staffing standards may need to be raised to meet the health and safety needs of facilities over time. The requirements in this rule are minimum baseline standards for safety and quality without accounting for resident acuity. We will continue to engage stakeholders as the requirements are implemented.

*Comment:* Many commenters expressed concern about potential systemwide impacts of the proposed changes, ranging from the potential for reductions in LTC facility admissions and census, facility closures, and the impact of those closures on residents and their families. Commenters gave scenarios of residents or individuals that may need admission to a LTC facility and not be able to find the care they need if fewer beds were available. Commenters suggested that residents in LTC facilities might face forced discharge or transfer if sufficient RNs and other staff were not available at the facility, resulting in inappropriate discharges to home or other inappropriate settings for residents. Some commenters expressed concern about readmission protections for residents when facilities say they can't readmit due to low staffing.

In addition, commenters stated that various issues may occur in other provider settings as the current state of nurse staffing at LTC facilities evolves. Some commenters noted that fewer LTC facility beds could result in hospitals having a harder time discharging patients in need of LTC. The commenters stated that without the ability to transfer patients in need of LTC to an appropriate facility, people in need of admission to a hospital might have to wait longer for an available bed. This could also result in a backup in the emergency department resulting in longer waits for care. A commenter stated that patients discharged from hospitals to LTC facilities have more acute clinical needs than patients discharged to home.

*Response:* While increased staffing needs in one provider setting can impact other provider settings, LTC facilities must be able to demonstrate that the care and services they provide meet the resident's needs. LTC facilities are responsible for compliance with 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. This rule provides flexibilities through phased implementation timeframes and hardship exemptions, which can provide temporary relief to facilities that are having workforce issues. We have built in these flexibilities for facilities while still prioritizing resident safety and quality of care. The minimum staffing standards support existing regulations and help to ensure the staff needed to meet the care needs and improve the LTC facilities' ability to care for patients discharged from the hospital and prevent hospital readmissions. Although the practices of other healthcare settings are not within the scope of this rule, we intend to monitor its impact for unintended system-wide changes that may hinder or harm patient and resident care. We encourage LTC facilities to work with local hospitals to ensure safe care patient transitions. The requirements for participation at § 483.15(e)(1) are in place to ensure that facilities develop and implement policies that help facilitate the return of residents to the facility after a hospitalization. Facilities must have a sufficient number of qualified staff to meet each resident's needs, to protect resident health and safety while supporting access to care. We will use available data for monitoring residents' health, and safety and any unintended consequences during the multi-year implementation of this final rule.

*Comment:* Commenters expressed concerns that the proposed rule would draw funding and staff away from home and community-based services (HCBS) to facility-based settings. Moreover, this would lead to an increased unmet need for HCBS, poorer health outcomes for individuals, and reduced access to training and support for caregivers. Furthermore, the commenter thought that it would lead to reduced access to culturally and linguistically appropriate HCBS which will negatively impact communities of color.

*Response:* The HCBS workforce comprises a diverse array of worker categories including workers who provide nursing services, assist with activities of daily living (such as mobility, personal hygiene, eating) or instrumental activities of daily living (such as cooking, grocery shopping, managing finances), and provide behavioral supports, employment supports, or other services to promote community integration. While these workers do include nurses (RNs and licensed practical nurses) and NAs, the HCBS workforce comprises many other workers (both with and without

professional degrees) that are not included in the minimum staffing requirement. Although there may be some overlap in demand for staff in LTC facilities and HCBS programs, we do not have reason to believe the overlap will be significant. We appreciate the comments, and CMS will continue to monitor these trends. Over time, additional, useful information will be supplied through finalized policies in the Medicaid access rule and this rulemaking concerning Medicaid funds dedicated to the direct care workforce in HCBS, LTC, and other institutional settings.

*Comment:* Some commenters included requests for staffing minimums for other categories of nursing home employees, including full time social workers and infection prevention control specialists. Other commenters suggested that CMS conduct research to determine why nurses are leaving the nursing workforce, noting that, since the COVID-19 PHE, many staff are going back to school for degrees not related to nursing.

*Response:* We agree that other LTC facility staff provide important services for resident well-being. However, suggestions related to establishing minimum standards for other types of employees are outside the scope of this final rule. We also agree that it is critical to understand the drivers of changes in the national nursing workforce and encourage interested parties to conduct research into these issues that can inform future policy decisions.

*Comment:* A commenter urged CMS to conduct research and rulemaking to enhance social work in nursing homes.

*Response:* We support the use of social work services in LTC facilities and encourage interested parties to conduct research into the care and services provided by social workers and the impacts to residents' highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. However, suggestions related to establishing minimum standards for other types of employees are outside the scope of this rule.

*Comment:* A commenter asked CMS to support and protect union rights through implementation of a labor relations quality measure.

*Response:* The protection of union rights through the development of quality measures or any other means is outside the scope of this rule. This rule, however, is intended to support all workers in nursing facilities by ensuring there is sufficient staff to care for

residents safely and thus reducing the burden on existing workers.

*Comment:* A commenter expressed concern that the proposed rule would undermine payments for LTC pharmacy services. For example, a facility census may decline resulting in a decrease in the use of pharmacy services causing various economic challenges for LTC pharmacies.

*Response:* We disagree with the commenter's assumption that implementation of this rule will result in an overall decline in resident census that undermines reimbursement and affects LTC pharmacy services. This final rule includes multiple flexibilities for eligible facilities located in areas affected by pronounced workforce shortages and provides staggered implementation periods to allow time for additional workforce development to comply with the requirements of this rule.

*Comment:* A commenter made suggestions to add additional items related to revenue and costs to the Federal cost reports that LTC facilities must complete and recommended that CMS publicly release that additional data after it is collected.

*Response:* Federal cost reporting changes are not within the scope of this final rule. We note that information collections require statutory authority. We will take the request under advisement.

*Comment:* Several commenters asked if every nursing home survey would assess compliance with the staffing requirements and staffing adequacy, while other commenters asked if we would bolster the survey process, to accommodate enforcement of the staffing standard. Commenters voiced concern about the additional time that would be required by surveyors to determine compliance with the minimum staffing requirements, and other commenters questioned whether States would get more funds for training and technical support to conduct surveys. Some commenters suggest increasing the State survey budget and the survey workforce so that enforcement of staffing requirements will be timely and successful.

*Response:* We appreciate the comments received on the survey process. We envision using a combination of PBJ data and onsite surveys to assess compliance with various aspects of these requirements.

We will publish more details on how compliance will be assessed after the publication of this final rule in advance of each implementation date for the different components of the rule. We intend to use the traditional process of

communication of information to providers and surveyors via CMS's Quality, Safety and Oversight Group (QSO) memoranda and publication of information in the CMS State Operations Manual (internet Only Publication, 100–07). The links to these resources are listed below.

- Policy & Memos to States and CMS Locations | CMS: <https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states-and-cms-locations>.

- Quality Safety & Oversight-Guidance to Laws & Regulations | CMS: <https://www.cms.gov/medicare/health-safety-standards/guidance-for-laws-regulations>.

We are also committed to robustly funding the survey, certification, and enforcement programs to the extent possible. The President's FY 2025 Budget calls for an increase in funding for these important programs and for the survey and certification funding to be shifted to mandatory spending starting in the FY 2026 budget to better align the continued need for surveys with the type of funding.

*Comment:* Several commenters asked for an evidence-based template and updated surveyor guidance for monitoring and enforcing staffing levels. In addition, commenters questioned whether surveyors will be taught principles of evidence-based staffing research so that their determinations of compliance with staffing minimums are neither subjective nor the opinion of the surveyor.

*Response:* We thank the commenters for their feedback. We will publish more details on how compliance will be assessed after the publication of this final rule in advance of each implementation date for the different components of the rule. We envision using a combination of PBJ data and onsite surveys to assess compliance with various aspects of the requirements. We note that since the requirements specify specific staffing minimum thresholds, the determination of compliance with these thresholds will be objective, and not subjective. However, our decisions to grant exceptions are based on criteria that will require the agency to use its best judgment (for instance, in determining whether a facility has made a good-faith effort to hire additional staff).

*Comment:* Many commenters expressed concerns related to the importance of identifying noncompliance and taking appropriate enforcement actions so that residents' health and safety are protected. Commenters asked about the timeframe

between the determination that a provider is found out of substantial compliance with the new staffing standards and any resultant enforcement actions, citing concerns about potential significant time lags. Many commenters suggested CMS consider survey results and PBJ data for compliance determinations and enforcement actions. Other commenters noted that PBJ data is available on a quarterly basis and could be used for more frequent compliance reviews. A commenter asked if day to day fluctuations in staffing will result in citations. Some commenters suggested rulemaking to adopt specific enforcement rules for the HPRD numerical minimums. Some commenters stated that when enforcement actions are taken, they are too severe. Several commenters urged CMS to establish detailed guidelines on when a surveyor should assess appropriate penalties at the harm or immediate jeopardy level whenever there is serious harm, injury, impairment or death of a resident. Others recognized that enforcement is critical to ensure successful implementation of the minimum staffing standards and that nursing homes should know that they face consequences for substantial non-compliance.

*Response:* We appreciate and will consider the comments as we move forward and recognize that rigorous data-driven enforcement will be critical to the successful implementation of this rule. We will publish more details on how compliance will be assessed and how enforcement remedies will be imposed after the publication of this final rule in advance of each implementation date for the different components of the rule. We envision using a combination of PBJ data and onsite surveys to assess compliance with various aspects of the requirements. Additionally, if finalized, the proposal for revisions to CMPs in the forthcoming FY 25 SNF payment rule will give CMS more flexibility to assess fines associated with the severity of the citation.

*Comment:* The PBJ allows staffing data to be collected from LTC facilities on a regular basis. Several commenters suggested that CMS improve PBJ implementation so that it allows facilities to report all hours worked by staff including nurses and nurse aides and offers facilities a reasonable opportunity to appeal/correct PBJ data. A commenter suggested that CMS should send letters to facilities that submit PBJ data showing staffing levels that do not comply with requirements

and ask for an explanation. Many commenters recommended monitoring PBJ staffing data and wanted automatic citations issued for failure to comply with the standards. One commenter suggested that Federal surveyors use the PBJ data as the basis for citations for deficiencies and to conduct more frequent reviews of facility compliance with HPRD minimums than what is currently required.

*Response:* Per Federal law, staffing data submitted by a facility to the PBJ system must be auditable back to payrolls and other verifiable information. Therefore, CMS does not agree that all hours worked by staff (such as hours that cannot be verified) should be reported and credited, but auditable back to verifiable information should be reported and credited to the HPRD calculations (unless they meet the reporting requirements). Furthermore, facilities have up to 45 days after the end of each quarter to review and make any corrections needed to the data prior to submission. Therefore, facilities already have the opportunity to correct their PBJ data. We note that providers will retain their ability to exercise existing regulatory provisions to dispute or appeal citations for noncompliance, such as informal dispute resolution. Additionally, CMS does inform providers of their staffing levels prior to public posting. However, we disagree that CMS should give facilities an opportunity for an explanation, as compliance with the requirements is based on whether the facility meets the specific required staffing thresholds, regardless of justification. A facility that in good faith believes that it cannot consistently meet the HPRD standards may request an exemption, pursuant to § 483.35(g) as set out in this final rule. For comments related to automatic citations, we appreciate the suggestion and note that surveys of compliance and enforcement actions are conducted pursuant to 42 CFR part 488, subparts E and F, respectively. We will publish more details on how compliance will be assessed after the publication of the final rule in advance of each implementation date for the different components of the rule.

*Comment:* Several commenters requested that CMS publicly identify nursing homes that fail to adjust staffing levels for resident acuity. Other commenters suggest that CMS should include easy to understand information about whether a nursing home meets the minimum staffing standards on Care Compare.

*Response:* As part of CMS' survey and enforcement activities, we currently publish data for all LTC facilities on the

Care Compare website. We appreciate the suggestions and are committed to providing consumers, families, and caregivers with useful information to help support their healthcare decisions. Care Compare will be updated to show whether a facility has an exemption and will note the extent to which a facility falls short of the minimum staffing standards.

*Comment:* A commenter suggested that PBJ and Minimum Data Set (MDS) be improved to ensure compliance with minimum staffing standards.

*Response:* We appreciate this suggestion, and welcome suggestions for improvement. However, the commenter did not provide details on how PBJ and the MDS could be improved.

*Comment:* A commenter requested that CMS issue guidance prior to the final rule on additional staffing standards based on resident acuity and activities of daily living (ADL) needs.

*Response:* We appreciate the suggestion. CMS will issue subregulatory guidance to surveyors for specific requirements after the publication of this final rule in advance of each implementation date for the different components of the rule. However, we note the existing regulations require facilities to consider residents' conditions and acuity when developing their facility assessment to determine the personnel needed to meet residents' needs. Subregulatory guidance for this requirement can be found in the State Operations Manual, appendix PP, sec. 483.70(e) (<https://www.cms.gov/medicare/provider-enrollment-and-certification/guidance-for-laws-and-regulations/downloads/appendix-pp-state-operations-manual.pdf>).

*Comment:* Some commenters suggested that CMS consider ways to enhance compliance among LTC facilities with automated data collection techniques or other forms of information technology.

*Response:* We appreciate the suggestion. CMS remains open to exploring ways that technology can be leveraged to streamline data collection and improve compliance and enforcement.

*Comment:* One commenter expressed concern that PBJ reporting guidelines are technical and the data submitted do not always reflect the actual staffing levels. The concern centered around rural providers with small census using one nurse per shift, the nurse stays onsite for the entire shift, including the lunch break. However, the PBJ reporting guidelines always exclude a 30-minute rest period, regardless of whether the

nurse took a 30-minute uninterrupted break.

*Response:* We appreciate the concern raised by the commenter. It is very important that PBJ data is auditable. Facilities need to deduct a 30-minute meal-break from each eight-hour shift. As the staffing data must be auditable back to payrolls, there is no way to audit and verify the portion of their meal break that was spent working versus eating. Also, some facilities pay for meal breaks, and some do not. Allowing some facilities to report hours for paid meal breaks would result in reporting higher levels of staffing based on whether or not a facility pays for meal breaks, instead of actual differences in the amount of direct resident care their staff provide. Therefore, to measure all facilities equally, we require all facilities to deduct 30 minutes per shift. Information on this and other policies related to PBJ can be found on the CMS website for Staffing Data Submission Payroll-Based Journal: <https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission>.

*Comment:* One commenter suggested better coordination between State surveyors and the CMS designated Quality Innovation Network Quality Improvement Organizations (QIN-QIOs).

*Response:* We thank the commenter for their feedback. CMS is committed to ensuring coordination between State surveyors and QIN-QIOs as they conduct their individual and unique responsibilities.

*Comment:* We received many recommendations for alternative policies or strategies for supplementing or enhancing the LTC facility workforce. Commenters suggested various ways of substituting staff when determining compliance with HPRD minimums set out in this rule: one commenter suggested allowing LPNs to substitute for NAs, another suggested facilities will substitute NAs for LPNs, yet another commenter related that LPNs and RNs can substitute for NAs in addition to their own job requirements. A commenter proposed the creation of a transportation aide role so that residents could move around the facility, and this would in turn improve quality of life. One commenter stated that expansion of training for paid feeding assistants would be beneficial to the residents. The same commenter suggested flexibility within the regulations to allow technology to supplement the workforce such as robots, that can deliver food to residents at their tables.

*Response:* We thank commenters for these recommendations. Under the

current regulations, facilities can already use many of these suggestions, such as using feeding assistants, transportation aides, and technology to supplement the nursing workforce in LTC facilities, paying nurse aides while they are in training, and using LPNs/LVNs to deliver some NA care. Facilities may continue to implement these strategies as needed to ensure that all residents receive high-quality care in accordance with their plan of care and consistent with the requirements for participation.

*Comment:* A small number of commenters addressed the relationship between the proposed requirements and CMS' statutory authority. A commenter noted that CMS is taking these minimum staffing requirement actions based on the statutory authority 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. This commenter urged CMS to establish higher minimum staffing levels in a way that fulfills this statutory mandate. One commenter suggested that CMS did not have authority to establish RN staffing standards for 24 hours per day, 7 days per week, and suggested that CMS should augment the current 8 hours per day, 7 days a week RN services requirement with a higher minimum RN HPRD to achieve our policy goal. Finally, one commenter contended that CMS lacks the authority to finalize the minimum staffing standards, suggesting that CMS cannot require HPRD standards or increase the current 8 consecutive hours of registered nurse hours a day 7 days a week minimum standard to 24 hours a day standard.

*Response:* We appreciate the comments received on whether or not CMS has the authority to enact these regulations. As discussed in section II.A.1. of this final rule, various provisions in sections 1819 and 1919 of the Act provide CMS with the statutory authority for the requirements of this rule. The Secretary has concluded that these HPRD levels and RN onsite 24/7 requirements are necessary for resident health, safety, and well-being, under sections 1819(d)(4)(B) and 1919(d)(4)(B) of the Act, which instruct the Secretary to issue such regulations relating to the health, safety, and well-being of residents as the Secretary may find necessary. We agree with the commenter that section 1819(b)(2) and 1919(b)(2) of the Act, which require facilities to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, also

supports CMS authority to establish these requirements. Also, 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. While sections 1819(b)(4)(C) and 1919(b)(4)(C) of the Act state that a facility must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week, CMS is using separate authority as described above to establish these new requirements rather than the authorities found at sections 1819(b)(4)(C) and 1919(b)(4)(C) of the Act. Our goal is to protect resident health and safety, and the persistent and pervasive safety issues described in the proposed rule and in this final rule make it clear that it is necessary to establish new minimum requirements to fulfill the Secretary's responsibility to establish other requirements related to resident health and safety.

## 2. Definitions (§ 483.5)

We proposed 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.<sup>57</sup> We also proposed to add the definition of "representative of direct care employees" who 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. We received no comments on how we define hours per resident per day (HPRD). We received no comments on how we define representative of direct care employees. As such, we are finalizing the definition of "hours per resident day" (HPRD) and "representative of direct care employees" as proposed.

**Final Rule Action:** We are finalizing the definition of "hours per resident day" as the total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS. We are finalizing the definition of "representative of direct care employees" as 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.

## 3. Minimum Staffing Standards (§ 483.35(a))

In the proposed rule, we discussed revisions to the Nursing Services regulations at § 483.35(a)(1)(i) and (ii) to require facilities to meet minimum staffing standards—.55 HPRD of RNs and 2.45 HPRD of NAs (see 88 FR 61366 through 61370, 61428). Specifically, at § 483.35(a)(1)(i) we proposed individual nurse staffing type standards for RNs and NAs. We proposed to require facilities to meet minimum staffing standards—.55 HPRD of RNs and 2.45 HPRD of NAs—as well as to maintain sufficient additional 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 new § 483.71. We also solicited comments on establishing an alternative total nurse staffing standard, such as 3.48 HPRD, in place of a requirement only for RNs and NAs, or in addition to a requirement for RNs and NAs that could also encompass other nursing staff types. We considered an alternative standard of 3.48 HPRD for total nurse staffing—inclusive of the 0.55 HPRD of RNs and 2.45 HPRD of NAs minimum standards—based on the literature evidence (see 88 FR 61259 through 61366 for more details). CMS solicited comments on a minimum total nurse staffing standard of 3.48 HPRD, the necessity of a total staffing standard, and whether a total staffing standard should be adopted in place of a requirement only for RNs and NAs, or in addition to a requirement for RNs and NAs. We also emphasized that comments on the recommended policy or an alternative, must support and promote acceptable quality and safety in LTC facilities, which is the intended goal. We also requested that commenters submit evidence and data to support their recommendations to the extent possible.

**Comment:** We received many comments on the numerical HPRD minimum staffing standards. Commenters offered numerous reasons for supporting CMS efforts to establish minimum staffing standards, including increased accountability for facilities regarding the treatment of staff and residents, and the care provided. Commenters that supported establishing numerical HPRD standards also noted that such requirements would assure that safety is not compromised for both staff and residents. Commenters also stated that the proposed staffing

requirements should be considered as the start of improvements to be built upon over time, rather than as the singular end goal for addressing LTC facility safety and quality challenges. Others commended the Administration for proposing minimum nurse staffing standards, stating that "the NPRM [notice of proposed rulemaking] represents a paradigm shift in nursing home oversight to promote quality of care". Another commenter stated, "we strongly encourage CMS to adopt the proposed standards. These standards will set a floor (baseline) that prevents overall resident harm and jeopardy and ensure all residents, regardless of race or geography, and allows for nursing home to staff above those standards based on resident acuity." Another commenter noted that CMS must clarify that, "the minimum staffing levels are considered to be only for residents with the lowest acuity needs."

**Response:** We thank commenters for their support in improving resident care and safety. We agree that establishing minimum staffing requirements will promote quality in LTC facilities and ensure safety is not compromised for both staff and all residents. Facilities must meet, at a minimum, the 3.48 total nurse staffing, .55 RN, and 2.45 NA HPRD (as finalized in this rule and discussed in detail later in this section) regardless of the individual facility's resident case-mix, as these requirements establish the minimum floor (baseline) for staffing requirements. We expect that many facilities will need to staff above the minimum standards to meet the acuity needs of their residents depending on case-mix and as mandated by the facility assessment required at § 483.71.

**Comment:** We received several comments on establishing individual minimum standards for RNs and NAs. Some commenters supported establishing individual standards, noting that setting individual minimum staffing standards will "avoid aggregating HPRD across job classifications." For example, commenters noted that mandating a specific number of minimum hours for care provided by NAs would increase facility accountability and reduce discretion regarding the type of staff facilities may use to comply with the requirement. In addition, one commenter noted the specific individual standards for RNs and NAs would improve some residents' health and quality of life.

Commenters also questioned our use of the acronyms "NA" (nurse aide) versus "CNA" (certified nurse aide) and requested clarification regarding the

<sup>57</sup> <https://data.cms.gov/provider-data/dataset/4pq5-n9py>.



type of staff that would count towards the minimum requirement. Some commenters supported having a minimum staffing standard for NAs. However other commenters suggested that CMS require the use of CNAs since this is a Federal requirement and strongly opposed the use of “uncertified and untrained staff”. For example, one commenter noted that nursing assistants are required to meet certification standards within a specified period and indicated that nursing homes are not allowed to rely on NAs to provide basic care unless they meet the training requirements as required.

*Response:* We appreciate the commenters’ support for the minimum HPRD staffing standard. 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.<sup>58</sup> Nurse aides include certified nurse aides (CNAs), aides in training and medication aides/technicians, which all require training. Specifically, at § 483.5 existing regulations define “nurse aide” as any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in 42 CFR 488.301. As such, we disagree with having a staffing standard for CNAs only. In addition, in some facilities there is an overlap in responsibilities between CNAs, medication aides/technicians, and aides in training. We agree with commenters that having a separate, specific minimum staffing level requirement for RNs and NAs is important to improving resident health and safety and are finalizing this proposed requirement at § 483.35.

*Comment:* Many commenters who supported establishing numerical staffing standards recommended ways to strengthen the proposed minimum HPRD staffing requirements. The commenters stated that the proposed 0.55 RN and 2.45 NA HPRD requirements were “not sufficient to

protect the health and safety of residents” and “risk normalizing staffing levels associated with poor quality of care. . . .” Commenters also noted that facilities in both urban and rural areas already meet far higher nurse staffing standards than what CMS proposed and as such CMS should consider strengthening the proposed minimum nurse staffing standard. Commenters offered varying modifications to strengthen the proposed minimum nurse staffing standard, which included establishing a range of minimum staffing standards based on resident acuity and need for assistance with activities of daily living (ADLs) or establishing a higher HPRD as the minimum standard. For example, one commenter suggested that CMS revise the proposal to require facilities to meet a minimum 0.75 HPRD for RNs and 2.8 HPRD for NAs, noting that many nursing homes currently staff at an average of 3.63 HPRD which is above the proposed minimum standard. While some commenters supported establishing specific minimum requirements for RNs and NAs, several commenters strongly supported the creation of a minimum total direct care nurse staffing standard that would include minimum HPRD requirements for RNs and nurse aides and incorporate LPNs/LVNs either as part of a minimum licensed nursing standard that includes a minimum RN HPRD or as a separate minimum LPN/LVN HPRD standard. For example, one commentator indicated that “a minimum standard for LPNs would reinforce a minimum standard of 1.4 HPRD for licensed nurses”. Others suggested “LPNs need to count toward either RN or CNA mandated ratios. One commentator noted that “LPNs should also be counted in the 0.55 RN HPRD requirement.” Commenters who supported the inclusion of LPNs emphasized the unique role that LPNs play in providing quality care and the importance of capturing their contributions in a minimum nurse staffing standard. Commenters indicated that LPNs provide essential skilled care and critical services that are not within a CNA’s scope of practice. Furthermore, some commenters shared concerns about the unintended consequences that establishing a minimum nurse staffing standard that lacks LPNs may have on staff retention and career advancement. These commenters suggested that our proposal, and the lack of incorporating LPNs into the requirement, marginalized the contributions of LPNs in the LTC facility workforce. However, commentators were not consistent in

their suggestions for HPRD ratios of LPN/LVNs.” Lastly, many commenters strongly supported a minimum threshold of 3.48 HPRD for total nurse staffing and suggested finalizing an even higher numerical standard than the 3.48 total HPRD, ranging up to 4.2 HPRD.

*Response:* We appreciate the thoughtful and nuanced comments received on the proposed minimum HPRD staffing standard and the suggestions for revision to further strengthen the requirement. Ensuring that nursing home residents receive safe, reliable, and quality care is a critical function of the Medicare and Medicaid programs and a top priority for CMS. As such, requiring Federal minimum nurse staffing standards will create a consistent minimum floor specific to nurse staffing levels and reduce the variability in nurse staffing across States. In addition, while establishing minimum nurse staffing standards will create broadly applicable standards at which all residents across all facilities will be at significantly lower risk of receiving unsafe and low-quality care. We emphasized in the proposed rule and reiterate here that facilities are also required to staff above the minimum standard, as appropriate, to address the specific needs of their resident population (88 FR 61369). We expect that most facilities will do so in line with strengthened facility assessment requirements at § 483.71 (88 FR 61368). As stated in the proposed rule, we will also revisit the Federal minimum staffing standard over time, as the rule is implemented, to determine whether upward revisions in staffing levels are needed.

We appreciate the comments received requesting that we incorporate a total nursing standard that includes a minimum HPRD specifically for LPN/LVNs. In the proposed rule, we indicated minimum individual standards for RNs and NAs based on evidence demonstrating that RNs and NAs have a consistently greater demonstrable effect on quality. While we believe LPNs, in addition to all staff, are vitally important to resident care, we detailed in the proposed rule the research evidence that suggest that a greater RN presence has been associated with higher quality of care and fewer deficiencies. We also noted literature in support of having adequate staffing levels, specifically NAs, to prevent a high rate of unusual patient safety events such as resident falls.

We recognize the importance of the role of LPN/LVNs staffing in LTC facilities and acknowledge their increasing responsibilities for providing resident care. However, we found

<sup>58</sup> 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/>.

insufficient research evidence that supports a particular minimum standard for LPN/LVNs nor did we receive supporting evidence for particular minimum standards for LPN/LVNs from commenters. We also noted that facilities must maintain sufficient additional 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 (88 FR 61368). Additionally, hours worked by LPN/LVNs may be counted toward the 3.48 total nurse staffing HPRD requirement being finalized as part of this rule.

We agree that a higher HPRD of nursing staff such as 0.75 HPRD of RNs, 2.8 HPRD of NAs, and 4.1 HPRD of total nurse staffing could produce increased improvements in safety and quality of resident care and that the alternative approach to establish a minimum total nursing standard is one effective way to create improvements while also providing flexibility. We also recognize that there is evidence that suggests that a lower HPRD of nursing staff—0.45 HPRD of RNs, 2.15 HPRD of NAs, and 3.30 HPRD of total nurse staffing could lead to a 3.3 percent of care delayed, whereas having no minimum staffing requirements could result in a higher *i.e.* a. 5.6 percent of care delayed. However, we maintain that establishing individual minimum staffing standards for RNs and NAs specifically is the best approach to increasing quality and safety given the evidence suggesting that RNs and higher numbers of NAs significantly improve quality.

We also recognize that establishing a total nurse staffing standard could produce increased improvements in safety and quality of resident care. We agree with commenters' assertions that the proposed staffing standards could be strengthened, and we believe that the addition of a total nurse staffing standard will promote resident safety and high-quality care. We have chosen 3.48 HPRD as the minimum total staffing standard, which is inclusive of individual staff-specific standards, in light of comments on the proposed rule indicating the value of this addition and evidence from the 2022 Nursing Home Staffing Study, in addition to other factors discussed in the proposed rule. Finally, we share the concern raised by commenters about the potential for unintended consequences resulting from the absence of an LPN/LVN standard, noting facilities may be incentivized to terminate LPN/LVNs and replace them with either nurse aides, RNs or a lower paid unlicensed staff. A total nurse staffing standard

guards against these unintended consequences. Therefore, we are finalizing a minimum standard for total nurse staffing and requiring minimum individual standards for RNs and NAs. Specifically, we are finalizing a requirement for facilities to provide the minimum 3.48 HPRD of total nurse staffing, which must include at least 0.55 HPRD of RNs and 2.45 HPRD of NAs. We note that facilities may use any combination of nurse staffing (RN, LPN/LVN, or NA) to account for the additional 0.48 HPRD to comply with the total nurse staffing standard. 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 revisions to the staffing minimums are warranted, we will revisit the minimum staffing standards with continued consideration of all relevant factors.

*Comment:* Many commenters did not support the proposed rule and establishing minimum staffing standards, whether at the individual or total nurse staffing levels. Commenters cited several concerns, including workforce shortages, costs of implementing the proposed changes, Medicaid underfunding, the diversity of nursing homes and their resident needs, and potential unintended consequences. For example, one commenter stated that “the proposed rule fails to consider in a serious way where nursing homes will find the estimated 12,639 additional registered nurses (RNs) and 76,376 additional nurse aides (NAs) needed to comply with its requirements.” Other commenters suggested that compliance with the HPRD minimums will be difficult or impossible to achieve with staffing shortages and major challenges with workforce training and development. Many commenters focused on the challenges faced by rural facilities, noting that they may face greater challenges recruiting staff.

Several commenters shared concerns regarding the costs and burden imposed by the proposed rule and opposed a minimum staffing standard without dedicated funding to support its implementation. These commenters suggested that the cost of compliance would create unsustainable financial burdens for facilities and negatively impact residents by forcing facilities to limit admissions or close. For example, we received many comments from certain categories of facilities that expressed concerns about the potential impact of the minimum HPRD requirements on the operations of their

individual facilities and unique resident populations, such as tribally-owned facilities. However, several commenters also asserted that existing facility resources may be allocated to support staffing improvements and a minimum staffing standard, but indicated that facilities may be allocating such resources elsewhere. Moreover, commenters opposed to establishing a minimum staffing standard described the proposal as a “one-size-fits-all” numeric standard and strongly encouraged CMS not to proceed with finalizing the proposed rule, especially as the LTC workforce continues to rebound from the COVID-19 PHE. These commenters preferred that staffing standards be regulated at the State level and shared concerns about conflict between our proposal and States that already have staffing standards. Some commenters also suggested that there are currently facilities that demonstrate a high quality of care delivery, despite not currently meeting the proposed staffing levels. They also noted that there are facilities with some of the poorest quality outcomes based on CMS data who currently meet the proposed staffing levels.

*Response:* We appreciate the concerns raised by commenters regarding the challenges that a minimum staffing requirement will impose on LTC facilities. We also acknowledge the impact of the COVID-19 PHE on the health care industry, as discussed in the proposed rule, and recognize the challenges that nursing homes are facing as they relate to staffing. However, the COVID-19 PHE also highlighted the long-standing concerns with inadequate staffing in LTC facilities and we reiterate that evidence has shown that appropriate staffing made a crucial difference in quality of care as part of the overall response to the COVID-19 PHE in LTC facilities (see 88 FR 61356).

In the proposed rule, we outlined the need for a minimum nurse staffing standard noting the consequences of inadequate staffing, such as poor resident outcomes, adverse events, and delayed or omitted basic care tasks (88 FR 61355). We also included in the proposed rule an impact analysis for public comment and responses to comments received can be found in section VI, “Regulatory Impact Analysis,” of this final rule. We maintain that chronic understaffing continues in LTC facilities and evidence demonstrates the benefits of increased nurse staffing in these facilities. Indeed, a number of the comments we received on the proposed rule further highlighted the danger from a lack of sufficient

staffing for residents as well as the negative effects that chronic understaffing has on the nursing workforce. As such, we believe that requiring a Federal minimum nurse staffing standard will create a consistent floor (baseline) across all facilities and reduce the variability in the nurse staffing HPRD across States. In tandem, we believe policies finalized and discussed in this rule will help to advance equitable, safe, and quality care for all residents by reducing the risk of residents receiving unsafe and low-quality care. Therefore, we are finalizing our proposal to establish minimum nurse staffing standards for LTC facilities as discussed in this final rule.

We recognize the concerns raised by commenters regarding the cost of this rule, requests for additional funding, and workforce challenges. In light of these concerns, CMS announced a national campaign to support staffing in nursing homes.<sup>59</sup> As previously discussed, CMS will work to develop programs that make it easier for individuals to enter careers in nursing homes, investing over \$75 million in financial incentives such as tuition reimbursement. In addition, the implementation of the requirements in this final rule are phased-in to allow all facilities the time needed to prepare and comply with the new requirements specifically to recruit, retain, and hire nurse staff as needed. Finally, the rule also finalizes requirements that will allow for a hardship exemption in limited circumstances. While we fully expect that LTC facilities will be able to meet our requirements, we recognize that external circumstances may temporarily prevent a facility from achieving compliance despite a facility's demonstrated best efforts. Details regarding the finalized implementation timeframe and exemption framework are discussed in sections II.B.5 and II.B.7 of this rule, respectively (that is, a phased implementation up to 5 years for rural facilities and up to 3 years for non-rural facilities).

*Comment:* Some commenters suggested that the timeframe used to determine compliance with the minimum HPRD should be set for at least one year from the date of the survey for which the compliance is being determined. Specifically, commenters suggested that the lookback period should cover a full annual certification period and emphasized that facilities should be held accountable for

staffing decisions through an entire certification period. Comments also suggested that compliance should be determined by reviewing the facility's quarterly average HPRD and the lookback period should be no longer than 1 year. For example, one commenter stated that a quarterly average of a facility's HPRD for nurse staffing would align more closely to what consumers see on CMS Care Compare and what is used in the CMS Five-Star Quality System. They note that this type of consistency helps consumers and providers understand the requirements and monitor performance.

*Response:* We agree that creating consistency between what is publicly reported can better inform consumers and help facilities' understanding of the compliance requirements. As such, we are not finalizing our proposal to limit determinations of compliance with hours per resident day requirements to the most recent available quarter of PBJ System data submitted in accordance with § 483.70(p). We envision compliance will be assessed by using a combination of PBJ data and surveyor review and observations. We note that CMS already uses PBJ in the existing survey process, and we instruct surveyors to review a report of each facility's most recent quarter of PBJ data (or additional quarters if warranted), to help target their investigations of compliance. CMS intends to calculate each facility's staffing hours per resident per day based on data required to be submitted to CMS, such as existing data required at § 483.70(p) (as redesignated in this final rule) for electronic submission of staffing information (which is submitted through the PBJ system). As with all regulations, CMS publishes information on how compliance will be assessed in the State Operations Manual, appendix PP, and in the survey procedure documents found on the CMS web page for nursing home surveys.<sup>60</sup> Similarly, we will publish more details on how compliance will be assessed after the publication of this final rule in advance of each implementation date for the different components of the rule.

*Comment:* In addition to the proposed requirements, we also solicited comments on the following issues:

- The benefits and trade-offs associated with different staffing standards;
- Use of case-mix adjusted staffing HPRD for each facility (rather than

solely the facility's self-reported staffing information) to assess compliance with the minimum staffing standards, steps CMS can take to support LTC facilities in predicting what their case-mix adjusted staff might be and hire in expectation of that adjusted staffing level, and any resources facilities will need to proactively calculate their existing HPRD for nursing staff;

- Alternative policies or strategies we should consider to ensure that we enhance compliance, safeguard resident access to care, and minimize provider burden.

We received few comments related to the specific benefits and trade-offs associated with different staffing standards. Commenters stated that a requirement with individual staffing levels for specific nurse types reduces flexibility, which may result in non-compliance with the staffing requirements. In contrast, a total nurse staffing standard or combined total standard with individual thresholds for specific nurse types offers the flexibility to adjust as needed to day-to-day shifts in staffing. Moreover, commenters noted concerns about complying with minimum staffing standards that differ significantly from State staffing requirements. We also received very few comments related to adopting a case-mix adjusted staffing HPRD for each facility to assess compliance with the minimum staffing standards. However, commenters who provided feedback shared concerns with adopting case-mix adjustments to staffing HPRD standards, noting that the adjusted HPRD is derived from MDS data that offers a snapshot of the past and does not predict future staffing needs. Another commenter also shared concerns that the data currently used to determine case-mix adjustments is flawed and should not be used to create acuity-adjusted staffing requirements.

*Response:* We thank commenters for their thoughtful feedback in response to our comment solicitations. We agree that there are varying approaches to establishing a minimum staffing standard that would create greater flexibility, such as implementing a total nurse staffing standard with individual staffing levels for specific nurse staff. As discussed, we are modifying our proposal to finalize a higher total standard that will increase improvements in quality and safety while providing flexibility for providers in meeting the minimum standard. We agree with commenters who indicated that there are several factors to consider when making case-mix adjustments to assess compliance with the minimum HPRD staffing standards, including the

<sup>59</sup> <https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid>.

<sup>60</sup> <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes>.

need to ensure that facilities are able to proactively predict and calculate what their case-mix adjusted HPRD for staff might be. We believe that additional consideration is needed to analyze the use of case-mix adjusted staffing HPRD for each facility to assess compliance with the minimum staffing standard and will keep this suggested approach in mind for future rulemaking.

*Comment:* We solicited comments on evidence that States relied on when they adopted their specific minimum nurse staffing standards and the rate of compliance with the State's staffing standards. We did not receive comments that provide the evidence that States relied on when they adopted specific minimum nurse staffing standards, however we did receive very few comments on the impact of the minimum nurse staffing standards that States adopted. One commenter stated that overall number of nursing staff in nursing homes influences quality in nursing homes. Another commenter noted that "Washington State already has established staffing minimums. They are effective, they are enforced, and there is an established process for waivers."

We also received very few comments on rates of compliance with State staffing mandates. For example, one commenter stated that nearly 30 percent of their State's nursing homes have difficulty complying with their minimum staffing requirement. Another commenter noted that their State successfully improved compliance with minimum staffing requirements as a result of the implementation of administrative penalties for facilities that failed to comply with the State's minimum HPRD staffing requirement, citing public health data following the implementation of State's requirements.<sup>61</sup>

*Response:* We appreciate the comments received on compliance with State minimum staffing requirements, which appears to vary. We believe that establishing a national floor (baseline) for nurse staffing in nursing homes will lead to improvements in quality across all States and reduce disparities in care. However, as mentioned previously, the provisions of this rule are not intended to, and do not preempt the applicability of any State or local law providing a higher standard (in this case, a higher HPRD requirement for total nurse staffing, RNs and/or NAs, an RN coverage requirement in excess of at least one RN on site 24 hours per day,

7 days a week) than required by this final rule.

*Final Rule Action:* We are modifying our proposal and finalizing a requirement for facilities to provide a minimum total nurse staffing standard of 3.48 HPRD that must include at least 0.55 HPRD of RNs and 2.45 HPRD of NAs. We are not finalizing our proposal to limit determinations of compliance with hours per resident day requirements to the most recent available quarter of PBJ System data submitted in accordance with § 483.70(p).

#### 4. Registered Nurse 24 Hours per Day, 7 Days a Week (§ 483.35(b)(1))

The existing LTC facility staffing regulations require an RN to be onsite 8 consecutive hours a day, 7 days a week (§ 483.35(b)(1)).<sup>62</sup> 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. To address health and quality of care concerns and to avoid placing LTC facility residents at risk of preventable safety events due to the absence of an RN, we proposed to revise § 483.35(b)(1) to require LTC facilities to have an RN onsite 24 hours a day, 7 days a week.

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. We proposed that facilities would use this process to pursue a waiver of the 24 hours a day, 7 days a week requirement.

In addition to proposing the 24-hour, 7 days a week requirement for an RN, we noted that the separate existing requirement for the director of nursing (DON) at § 483.35(b)(2) would remain. Specifically, all LTC facilities are required to 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 likely 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 in the proposed rule, in which the NASEM recommended that the DON not be counted in the requirement for an RN 24 hours, 7 days a week.<sup>63</sup> Hence, in the 2023 proposed rule we also solicited comments on the following specific 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?

- Are there alternative policy strategies that we should consider to address staffing supply issues such as nursing shortages?

We received numerous comments regarding this proposal. Upon reviewing and analyzing these comments, we are finalizing a revision of the proposal as described in the responses below:

*Comment:* Many commenters, including some professional provider organizations, advocacy groups, and labor organizations supported the proposed requirement for an RN to be onsite 24 hours a day, 7 days a week that is available for direct resident care. Some of these commenters also noted that other experts and organizations have for many years been supporting a requirement for at least one RN on site at a LTC facility 24 hours a day, 7 days

<sup>61</sup> California Department of Public Health, 3.2 Nursing Hours Per Patient Day data as of November 6, 2019.

<sup>62</sup> 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/>.

<sup>63</sup> 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*.

a week. One commenter noted that it was the RN that put the “skilled” into “skilled nursing care” that residents require for a stay in a LTC facility. Some of these commenters stated that the current requirement was not only insufficient but put residents at risk of preventable safety events. Some commenters also supported the proposal for a 24/7 RN due to the increased acuity of residents and their complex medical, physical, and behavioral health care needs. As commenters noted, LTC facilities are caring for residents with complex medical and behavioral health needs. They are also caring for a growing population of short-term residents recovering from serious health care issues, surgery, or other injuries. Other commenters pointed out the improved outcomes to residents that result from greater RN staffing. Commenters also pointed out that greater RN staffing levels are associated with positive quality measures and fewer quality of care deficiencies, such as, fewer pressure ulcers; lower restraint use; decreased infections, including urinary tract infections (UTIs); less pain and the need for pain medication; improved activities of daily living (ADLs); less weight loss and dehydration, less use of antipsychotic medication; more morning care; and lower mortality rates.

Many other commenters, including some industry and provider organizations, supported the 24/7 RN requirement but were very concerned about some LTC facilities’ ability to comply with this requirement. Other commenters, for the same reasons, opposed the 24/7 RN requirement. Some commenters contended that the requirement was too expensive and was an unfunded mandate. While others contended that the requirement was not feasible due to a lack of available staff. As noted previously, however, some commenters denied there was a staffing shortage noting that the “shortage” could be resolved by higher pay and better working conditions.

*Response:* As demonstrated by the comment summary, we received an abundance of comments expressing diverse views on the 24/7 RN requirement. We appreciate the support for the proposal. We agree that an RN’s education, training, and scope of practice is necessary to provide the skilled care that LTC facility residents require for safe and quality care. The increased acuity of residents, both short and long-term, with their correspondingly complex medical, physical, and behavioral health care needs requires an RN’s expertise. In addition, the literature clearly

demonstrates improvement in resident outcomes when there is an increase in RN staffing. While we acknowledge the assertions by the commenters who were either concerned about the feasibility of the proposal or opposed to the proposal, we believe that the benefits of improving resident health and limiting preventable safety events by a stronger RN presence are vital. Therefore, we are finalizing the 24/7 RN proposal with revisions as detailed below.

*Comment:* Some commenters stated that a 24/7 RN was unnecessary for resident care. They pointed out that the residents are sleeping during the night and do not require an RN’s services. They also asserted that the care staff at most SNFs can provide quality care by following care plans and initiating the protocols established by the RN during the day without the RN being on site 24 hours a day. They contended that the only facility where RNs are needed around the clock are hospitals, especially in the areas of critical care. One organization noted that according to its members the majority of LTC facilities do not have an RN on site 24/7.

*Response:* We agree with the commenters that LPN/LVNs and NAs can provide quality care by following the care plans and protocols established by an RN. However, it is the RN’s education, training, and scope of practice, especially in nursing assessment, that is missing from resident care when an RN is not readily available. Residents can have changes in their physical and behavioral health at any time of the day. These changes could possibly require that the nursing staff assess the resident to determine whether there needs to be a change to a resident’s care, such as the administration of some pro re nata or PRN<sup>64</sup> medications; whether consultation with another health care provider, such as a physician is required; or whether the resident requires care beyond what the LTC facility could provide, requiring a transfer to another facility such as an acute care hospital. It is an RN whose education, training, and scope of practice includes the nursing assessment skills needed to make these determinations and the training and expertise to provide the quality of

nursing care residents require in such circumstances.

*Comment:* Some commenters not only supported the proposal for an RN 24/7 but also recommended that the requirement be strengthened. Many commenters were concerned about LTC facilities only being required to have the RN “available” to provide direct resident care and not requiring the RN to be “providing” direct resident care. These commenters recommended that the requirement be strengthened to require that the RN be providing direct resident care as that is the level of care that should be provided in a LTC facility. These commenters agreed with the 2022 Nursing Home Study that more RN staff should result in fewer deficiencies in care; however, they also insist that the RN cannot be simply “present” in the LTC facility. They contend that while having an RN onsite 24/7 in LTC facilities is important for resident care quality and safety, it is the active contributions and clinical expertise of RNs that ensures the delivery of skilled quality care for residents. Other commenters recommended that there be more than one RN onsite. For example, some commenters recommended one RN for every 100 residents.

*Response:* We appreciate the commenters support for the 24/7 RN proposal. Regarding the commenters that recommended strengthening the requirement by requiring one RN for every 100 residents, we do not agree with those comments. We believe that having a RN onsite 24/7 to help with preventable issues and creating a specific standard to ensure residents receive on average at least 0.55 hours of RN care per day is a stronger approach to improve resident health and safety than requiring one RN for every 100 residents. We are thus finalizing a total nurse staffing requirement of 3.48 HPRD that must include RN direct care levels of at least 0.55 HPRD. Although this does not go as far as requiring direct care from a 24/7 RN would, it will still provide for greater required RN direct care than current standards do. These requirements are set forth at § 483.35(b)(1) as finalized in this rule. Thus, the RN direct care staff requirement will be adjusted according to the number of residents in the facility. Regarding the commenters who recommended changing the proposed requirement that an RN be “available to provide direct care,” to require the RN “providing direct resident care”, we are not modifying the proposed requirements to incorporate that comment. The total nurse staffing requirement finalized in this rule

<sup>64</sup> PRN medications are medications that are given as needed when certain circumstance occur. Those circumstances would be indicated in the medication order. For example, a PRN medication could be given when a resident has a temperature over a certain degree or for agitation. In a LTC facility, it would generally be a licensed nurse who makes the determination to give a PRN medication.

contains an RN direct care level of at least 0.55 HPRD. This requirement along with the requirement for a 24/7 RN available to provide direct resident care should provide the high-quality, safe care that residents need.

*Comment:* In the proposed rule, we specifically solicited comments on whether the DON should be counted towards the 24/7 RN requirement or should the DON only count under specific circumstances. Commenters were divided on this question. Many commenters opposed the DON being counted towards the 24/7 RN requirement, as well as any other RN that is assigned to administrative duties. They contended that only RNs providing direct resident care should be counted towards the requirement. Still other commenters thought the DON should be included since they would be onsite at the LTC facility and could provide direct resident care, if needed. However, other commenters did not oppose including the DON in the requirement, especially if the resident census was below 30 residents.

*Response:* As discussed in the previous comment, we are finalizing the 24/7 RN requirement to require that the RN is available to provide direct resident care as proposed. Therefore, if the DON is a RN and is available to provide direct resident care, then the DON will count towards this requirement. We are not establishing a specific resident census for this requirement because we have no reliable evidence upon which to base a specific number of residents for this requirement.

*Comment:* Many commenters were concerned about the statutory waivers cited in the proposed rule and CMS's

assertion that the statutory waiver would apply to the proposed 24/7 RN requirement. They contended that these waivers diminished the requirement for a 24/7 RN and would result in a reduced quality of care for residents. Other commenters also noted that these statutory waivers were difficult to operationalize and were rarely granted. Specifically, commenters noted that the requirements for the statutory waiver were difficult for many LTC facilities to meet, such as the requirement for SNFs to be in a rural area. Some commenters thought these waivers could actually undermine the 24/7 RN requirement by enabling too many LTC facilities to avoid the requirement. At least one commenter recommended that LTC facilities use the same exemption criteria proposed as § 483.35(g) (finalized at § 483.35(h) as discussed in this rule), which would be applied to hardship exemptions for the minimum nurse HPRD standards set forth at proposed § 483.35(b)(1) (finalized at § 483.35(c)(1) as discussed in this rule).

However, other commenters contended that it was unnecessary for the RN to even be on site at the LTC facility 24/7. These commenters stated that part of the 24 hours could be satisfied through some type of "virtual" presence by an RN. Commenters suggested that an RN could be available by phone, internet, or be able to get to the LTC facility within a certain amount of time, such as 30 minutes. Commenters stated that a one-size-fits-all approach was unnecessary, and requirements should be based on resident acuity. Commenters insisted that by allowing for a part of the 24/7 RN coverage to be virtual, each LTC facility could determine if their resident

population needs an RN on site 24/7 or whether the RN could be virtually present during a part of the day. Some commenters specifically recommended that an RN could virtually support LPNs on the evening and night shifts. There were also commenters who noted that while there was a process for obtaining a hardship exemption to the minimum nurse staffing requirement, there was no waiver or exemption process for the 24/7 RN requirement.

*Response:* The current requirement is that the LTC facility provide 24 hours of licensed nursing services (RN or LPN/LVN) and RN services 7 days a week for 8 consecutive hours per day as set forth at existing sections § 483.35(a) and (b). There are two waivers discussed in § 483.35 of the LTC participation requirements that are set forth in paragraphs (e) and (f) (redesignated in this final rule as paragraphs (f) and (g), respectively). The requirements for these waivers come directly from the statute, specifically section 1819(b)(4)(C)(ii) and 1919(b)(4)(C)(ii) of the Act, respectively. Since these two waivers are statutory, the waivers can only be removed or modified in detail by legislation. Thus, the waivers in existing § 435.35(e) and (f) (redesignated as paragraphs (f) and (g) in this final rule) will not be changed except for conforming changes, which we will discuss further, to ensure that the statutory waivers do not conflict with the regulatory flexibilities finalized in this final rule at § 483.35(h). To assist readers and provide clarity, table 2 provides an overview of the differing requirements for the statutory waiver at § 483.35(e) and (f) (finalized as paragraphs (f) and (g) in this rule).

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**Table 2: Requirements for the LTC Staffing Statutory Waivers by Facility Type**

Facility Type*	NFs*	SNFs*
<b>Statutory Citation</b>	Section 1919(b)(4)(C)(ii) of the Act	Section 1819(b)(4)(C)(ii) of the Act
<b>Regulatory Citation and requirements that can be waived</b>	<p>§ 483.35(e) Nursing services. Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis (<i>final rule redesignates this paragraph as paragraph (f)</i>)</p> <p>The <u>State</u> can waive the following requirements:</p> <ol style="list-style-type: none"> <li>1. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.</li> <li>2. The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week (<i>final rule revises to must have a RN onsite 24 hours per day, for 7 days a week</i>).</li> </ol>	<p>§ 483.35(f) Nursing services. SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week. (<i>final rule redesignates this paragraph as (g) and revises title</i>)</p> <p><u>The Secretary</u> can waive the following requirement:</p> <ol style="list-style-type: none"> <li>1. The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week (<i>final rule revises to must have a RN onsite 24 hours per day, for 7 days a week</i>).</li> </ol>
<b>Criteria that must be met to be eligible for the statutory waiver</b>	<ol style="list-style-type: none"> <li>1. The facility must demonstrate to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.</li> <li>2. The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.</li> <li>3. The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.</li> <li>4. A waiver is subject to annual State review.</li> <li>5. In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel.</li> <li>6. The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the</li> </ol>	<ol style="list-style-type: none"> <li>1. The facility is located in a <b>rural area</b> and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area.</li> <li>2. The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week.</li> <li>3. The facility either— <ul style="list-style-type: none"> <li>• Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, <b>OR</b></li> <li>• Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;</li> </ul> </li> <li>4. The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the</li> </ol>

need to have some flexibility with the 24/7 RN requirements. We are especially concerned about those LTC facilities that meet the requirements for hardship exemptions. If a LTC facility is unable to meet the minimum staffing requirements as set forth at § 483.35(b) (as finalized in this rule), it also might not be able to comply with the 24/7 RN requirement because this could be an indication of the LTC facility's difficulty in obtaining staff in general. Conversely, if a LTC facility does not meet the requirements for a hardship waiver, it should be able to comply with the 24/7 RN requirement by the required implementation deadlines. Thus, we are finalizing an additional exemption for facilities that experience a hardship complying with the 24/7 RN requirement. This exemption will be in addition to the existing statutory waiver process set forth at § 483.35(e) and (f) (finalized in this rule as paragraphs (f) and (g)). Specifically, we are revising the requirements at proposed § 483.35(b) (finalized at § 483.35(c)(1) as discussed in this rule) to indicate that facilities must have a RN onsite 24 hours per day, 7 days a week that is available to provide direct resident care, except when this requirement is waived in accordance with the existing statutory waivers at § 483.35(e) and (f) (redesignated as paragraphs (f) and (g) as discussed in this rule) or exempted in accordance with the criteria for regulatory flexibilities at § 483.35(h). Section 483.35(h) specifies that a facility may qualify for a hardship exemption of 8 hours a day from the 24/7 RN requirement if the facility is located in an area where the RN to population ratio is a minimum of 20 percent below the national average, as calculated by CMS, by using data from the Bureau of Labor Statistics and Census Bureau. The finalized regulatory flexibilities and criteria for eligibility at § 483.35(h), including the basis for why such eligibilities have been set at current thresholds, are discussed in detail in the next section, section II.B.5. of this rule. We expect that those facilities currently meeting the 24/7 RN staffing requirement will continue meeting the requirement.

Furthermore, we are adding a requirement to specify that for any periods when the onsite RN requirements are exempted in accordance with the exemption criteria at § 483.35(h), facilities must have a registered nurse, nurse practitioner, physician assistant, or physician available to respond immediately to telephone calls from the facility. At existing § 483.35(e) (finalized at

§ 483.35(f)) we are modifying the heading of the paragraph to read "Nursing facilities: Waiver of requirement to provide licensed nurses and a registered nurse on a 24-hour basis". This paragraph applies to NFs only and the modified heading helps to clarify those requirements that are applicable to the waiver set out at section 1919(b)(4)(C)(ii) of the Act. In addition, we are modifying the language at existing § 483.35(f) (finalized at § 483.35(g)) to revise the heading of the paragraph to read "SNFs: Waiver of the requirement to provide services of a registered nurse for at least 112 hours a week". This paragraph would be applicable to facilities that meet the statutory qualifications for the waiver set out at section 1819(b)(4)(C)(ii) of the Act.

Given that this rule finalizes an additional regulatory flexibility for facilities to receive an exemption of 8 hours per day of the 24/7 RN requirement, we want to clarify that facilities who may also meet the requirements for the statutory waivers as detailed at existing sections § 483.35(e) and (f) (finalized as paragraphs (f) and (g) in this rule) will still have the ability to choose which process they want to pursue to achieve regulatory flexibility from the 24/7 RN requirement. For example, a SNF may be exempted from 8 hours per day of the 24/7 RN requirement if they meet the criteria specified in § 483.35(h). If this SNF is rurally located, then in accordance with existing § 483.35(f) (finalized in this rule at paragraph (g)) this facility may choose to instead pursue the statutory waiver for SNFs to achieve greater flexibility from the 24/7 RN requirement based on their specific situation and ability to meet the criteria outlined by the statute for the waiver rather than pursue the 8 hours per day exemption provided under new § 483.35(h).

*Final Rule Action:* We are finalizing with revisions the proposed requirement for an RN to be onsite 24 hours a day, 7 days a week and available to provide direct resident care. The RN can be the DON; however, they must be available to provide direct resident care. Also, LTC facilities that qualify for a hardship exemption to the minimum nurse staffing requirement set forth at § 483.35(b)(1)(i) in accordance with the criteria outlined at § 483.35(h) (as finalized in the rule) may also request an exemption of 8 hours per day of the 24/7 RN requirement. We have added this as we believe that additional flexibility is needed for facilities as they adopt the 24/7 RN requirement. We have added a requirement at

§ 483.35(c)(2) to specify that for any periods when the onsite RN requirements in are exempted in accordance with § 483.35(h), facilities must have a registered nurse, nurse practitioner, physician assistant, or physician available to respond immediately to telephone calls from the facility. In addition, we are modifying the language at existing § 483.35(e) (finalized at § 483.35(f)) to revise the heading of the paragraph to read "Nursing facilities: Waiver of requirement to provide licensed nurses and a registered nurse on a 24-hour basis". We are also, modifying the language at existing § 483.35(f) (finalized at § 483.35(g)) to revise the heading of the paragraph to read "SNFs: Waiver of the requirement to provide services of a registered nurse for at least 112 hours a week".

#### 5. Hardship Exemptions From the Minimum Hours per Resident Day Requirements (§ 483.35(g))

We proposed at new § 483.35(g), that facilities could be exempted from the 0.55 HPRD of RNs and/or 2.45 HPRD of NAs requirements if they were found non-compliant with the HPRD requirements and met four eligibility criteria, based on location, good faith efforts to hire, disclosure of financial information, and were not excluded based on the prior year's citations, failure to submit data to the PBJ, or having been designated as a Special Focus Facility. We stated that determinations regarding exemptions would be made during a survey. We also proposed that facilities could only receive an exemption from the proposed minimum HPRD requirements and not the proposed 24/7 RN requirements. We noted that a waiver of the proposed 24/7 RN requirements must be granted in accordance with the existing statutory waivers at § 483.35(e) and (f). We further proposed that the Secretary, through CMS or the applicable State Agency, would make the determination about exemption from the HPRD requirements and that such exemptions would be in effect for one year and renewable annually if facilities continued to meet the exemption requirements. We received a large number of comments that addressed exemptions. Comments ranged from robust objection to any exemptions, to support for exemptions as proposed or in concept, with both opposing and supporting commenters recommending a wide variety of specific changes to revise and improve our proposal. These comments reflected disparate and often opposing views on the provision of exemptions. In addition to proposing specific exemption criteria,



we also solicited comment on several specific questions related to exemptions.

We discuss and respond to these comments and responses to our questions in detail below.

*Comment:* Many commenters objected to allowing any exemption from the HRPD requirements. Some commenters stated that understaffing results in falls, injuries, and even death. Some commenters stated that the proposed exemptions would normalize inadequate staffing, depress wages, and would be dangerous and undermine or jeopardize the health and safety of residents. Other commenters stated that every nursing home resident deserved high quality care, regardless of their geographic location or other factors. One commenter stated that CMS must stop putting the financial priorities of the nursing home industry above the basic needs and dignity of nursing home residents. Some commenters suggested that certain facilities, including rural facilities, should be given special consideration, while others suggested that no facility should be given special consideration. Several commenters stated that they believed there should be progressive enforcement of the requirement, with reduced penalties in clear instances of a good faith effort to meet the staffing standards.

*Response:* We appreciate all of the commenters' concerns and suggestions. Our goal is to promote safe, high-quality care for all residents. We also recognize the need to strike an appropriate balance that considers the current challenges some LTC facilities are experiencing, particularly in rural areas. We have decided to retain the availability of exemptions under certain circumstances for select facilities, which would include some that are rural, after consideration of the comments, recognition of both quality of care and access to care concerns. We note the continued availability of recourse when there is a quality of care concern, including those that may be related to safety and staffing availability, such as complaints to survey agencies, QIOs, and State long-term care ombudsman programs. Exemptions may remain in place only until the next standard survey, and we expect any LTC facility receiving an exemption to work toward full compliance with the staffing standards.

*Comment:* Some commenters stated that any exemptions should be limited in number and frequency and must be paired with specific elements of heightened scrutiny and transparency. Furthermore, the commenters asserted that the need for such an exemption

must be compelling. One commenter stated that only if facilities, at their current staffing ratios, are performing well on outcomes such as hospital readmission rates, nurse turnover, facility acquired injuries, anti-psychotic medication use, would there be a logical justification to give them a waiver. Commenters also recommended concrete standards and clear, measurable, and rigorous criteria for receiving an exemption. One commenter recommended that CMS narrowly tailor the workforce shortage exemption. Other commenters suggested many specific changes, such as:

- Capping the number of exemptions a facility can receive, to avoid facilities that are perpetually exempted;
- Prohibiting any facility that does not meet the staffing requirements from admitting new residents;
- Disqualifying facilities operating under an exemption from any type of value-based purchasing initiatives within either the Medicare or Medicaid programs;
- Requiring facilities with an exemption to demonstrate progress on reducing turnover and increasing wages;
- Appointing an independent entity to monitor performance of any facility with an exemption;
- Ensuring transparency around exemptions through such tools as prominent display of exemption status on Nursing Home Compare with a warning about the possible consequences of nursing understaffing, posted notice within the facility, and specific notice to any individual/family residing in or seeking admission, as well as the Long-Term Care Ombudsman Program;
- Requiring that the facility's staffing plans demonstrate consideration of nationally recognized best practices, such as PHI's 5 Pillars of Direct Care Job Quality; and that the facility provide evidence related to best practices beyond offering prevailing wages, such as enhanced benefits, expanded training programs, worker surveys to inform workplace improvements, improved scheduling policies, participation in job fairs, and partnerships with schools;
- Requiring "good faith efforts to hire and retain staff" to include documentation of recruiting efforts, a specific method for calculating and reporting staff turnover, and an explicit target and plan for reducing turnover, including regular reporting to CMS;
- Requiring "documentation of financial commitment to staffing" that includes investments in recruiting and retention, and evidence of increased wages;

- Requiring an alternate viable plan for meeting the needs of the residents in their care, not solely on financial difficulties;

- Establishing a sunset date for hardship exemptions; and
- Placing nursing homes granted an exemption on a 'do not refer' list that is distributed to area hospitals and other providers.

*Response:* We thank the commenters for their suggestions. The exemption framework provides qualifying LTC facilities with the opportunity to receive time-limited flexibility upon completion of several essential documentation and transparency requirements. We considered each option suggested. While we are not implementing all of them at this time, we have included some, including around transparency and we may consider them in future rulemaking. In response to the concerns raised, we have made some revisions. Specifically, we have removed the distance criterion and narrowed the availability of exemptions to those facilities in staff shortage areas where the supply of applicable healthcare staff (RN, NA, or combined licensed nurse, which includes both RNs and LVN/LPNs, and nurse aide) is not sufficient to meet area needs as evidenced by the applicable provider-population ratio for nursing workforce that is a minimum of 20 percent below the national average for the applicable exemption (RN, NA, or combined licensed nurse and nurse aide), as calculated by CMS, by using the Bureau of Labor Statistics and Census Bureau data. The area is the geographical area defined as the metropolitan statistical area (MSA) or nonmetropolitan 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](https://www.bls.gov/oes/current/msa_def.htm)). Furthermore, we agree that transparency to current and potential residents, as well as the State Long Term Care Ombudsman Program is a necessary element. We are therefore adding transparency requirements in order to receive an exemption. First, a facility must post in a prominent, publicly viewable location in the facility a notice of the facility's exemption status, the extent to which the facility does not meet the minimum staffing requirements, and the timeframe during which the exemption applies. Second, a facility must provide a similar notice to each resident or resident representative, and to each prospective resident or prospective resident representative, that includes a statement reminding residents of their rights to contact advocacy and oversight entities, as

provided in the notice provided to them under § 483.10(g)(4). Finally, the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Exemption information will also be publicly available on Care Compare. We considered capping the number of exemptions or establishing escalating requirements for subsequent exemptions, but at this time, find that the underlying requirements to obtain an exemption are sufficient to encourage ongoing good faith efforts to meet the new requirements, to evaluate facilities quality of care prior to granting each exemption, and to ensure that residents and their representatives are aware of the exemption status of the facility.

*Comment:* Many commenters stated that the proposed exemption process was unfair and unworkable. Others described it as not meaningful or too burdensome and limited to be useful. Other commenters supported the proposed process. One commenter noted that the proposed staggered implementation dates and exemption criteria reflect a nuanced understanding of the challenges faced by LTC facilities and called the exemption criteria reasonable. Another stated that the exemption process would only postpone the challenges of meeting the minimum staffing standards. Some stated that small, rural facilities most in need of an exemption would not be able to meet the criteria to qualify while others suggested that few facilities at all would be able to qualify, stating that the criteria will be difficult if not impossible for most nursing homes to meet in all but the extreme circumstances. Some commenters urged CMS to streamline the exemption requirements to offer greater flexibility. Some commenters stated that the process should not be punitive, but should help facilities comply with the rule or that the process should protect facilities from monetary penalties and have checks and balances to ensure facilities are not punished for not meeting unattainable goals. One commenter recommended that CMS create a waiver process that is available to all facilities without exclusions; does not entail citation; is attainable by any facility that is in need and that is making good faith efforts (reasonable process); and includes support from a QIO or another party to assist facilities in securing support resources to meet applicable needs. Some commenters stated that disparities between criteria for exemptions or waivers should be minimized and should be “somewhat uniform” since they relate to the issue

of insufficient workforce. One commenter stated that any exemption should be based on the availability of workers, compensation offered, and working conditions. Other commenters recommended adding an exemption for unforeseen circumstances, temporary weather-related staffing reductions, or exigent circumstances. One commenter noted that their State considers extraordinary circumstances such as natural disaster, catastrophic event or a national or State-declared emergency; location in a region that the health commissioner has declared is experiencing an acute labor shortage; and a verifiable union dispute as mitigating factors for understaffing. Another recommended that CMS create a protocol for State agencies to implement to ensure consistency and provided details of how their State implemented exemptions to State requirements. Finally, one commenter stated that they were pleased that compliance with the 24/7 RN requirement did not imply compliance with the minimum staffing HPRD standard and that the hardship exemption process cannot be used to circumvent that [24/7 RN] requirement. Another stated that adding additional requirements that already have a foundation in regulations is illogical and risks further erosion of an already fragile system.

*Response:* We appreciate the comments in support of the exemption process and have considered the concerns raised about it. We have determined, in the interest of resident health and safety, that it is not acceptable to significantly expand the exemption process. However, based on the feedback from commenters and concerns raised regarding access to care, as discussed previously we have modified our proposal to allow facilities that can demonstrate a limited supply of RNs (based on a provider-to-population ratio 20 percent below the national average) and meet the exemption criteria to receive an exemption from 8 hours per day of the 24/7 RN requirement. In keeping with the comments regarding uniformity and exemptions based on worker availability, we are also finalizing, as part of the exemption process, a comparable exemption criterion for determining the workforce unavailability criterion for the total nurse staffing 3.48 HPRD standard that we are finalizing. Specifically, we will incorporate a provider to population ratio for combined licensed nurse and nurse aide workforce into the exemption requirements where such a ratio must be

at least a minimum of 20 percent below the national average. As explained in the proposed rule (88 FR 61378), 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/>) 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. We note that facilities that do not receive an exemption will have the opportunities afforded by the enforcement process to address any noncompliance deficiency citations, such as informal dispute resolution processes and administrative and judicial appeals. We have determined that this is the appropriate set of criteria to use for exemptions from both the 24/7 RN requirement and the 3.48 total staffing standard as it is appropriate to apply the same criteria for workforce insufficiency (20 percent below the national average for the applicable staff category) across all exemptions.

*Comment:* Many commenters suggested that facilities that receive an exemption should have to demonstrate progress on staffing related issues. For example, one commenter recommended we add a provision to require the facility to increase retention to 75 percent or higher if the facility will utilize an exemption, as there are many methods that can be utilized to increase staff retention, including flexible work schedules, bonuses, well-trained managers/supervisors, incentive programs and much more. This commenter stated that reducing turnover rates will significantly increase resident care/safety as well as reduce

the recruitment burden on managers. Several commenters mentioned turnover rates in the context of retention and recruiting, and one suggested that, for RNs and/or CNAs and other nursing staff, if the turnover rate is higher than 35 percent, a facility should not meet the good faith effort requirement for an exemption. Another commenter suggested adding a provision that would bar nursing homes with a turnover rate higher than the State median from receiving hardship exemptions.

*Response:* We thank commenters for these suggestions. At this time, we are not adding additional requirements related to turnover to qualify for an exemption. The facility's staffing plan in accordance with § 483.71(b)(4), however, requires the facility to develop and maintain a staffing plan to maximize recruitment and retention of direct care staff, and is considered part of a demonstration of a good faith effort to hire. Retention and turnover may thus be considered in evaluating whether a facility is complying with its staffing plan in seeking exemption. We also note that information on turnover is publicly available on Care Compare. In 2022, CMS began posting levels of weekend staffing and rates of staff turnover and using these metrics in the Five Star Quality Rating System to help provide more useful information to consumers. In addition, CMS is adopting the Nursing Staff Turnover Measure for the SNF VBP program beginning with the FY 2026 program year. This is a structural measure that has been collected and publicly reported on Care Compare and assesses the stability of the staffing within an SNF using nursing staff turnover. This is part of the Administration's focus to ensure adequate staffing in long-term care settings and delivers on a commitment included in the President's Executive Order 14070, Increasing Access to High-Quality Care and Supporting Caregivers. Facilities would begin reporting for this measure in FY 2024, with payment effects beginning in FY 2026. While we are not adopting these suggestions at this time, we may consider them for future rulemaking.

*Comment:* Several commenters objected to the demonstration of financial commitment as an exemption criterion. Some commenters felt that this criterion was duplicative of the information that would be provided in the good faith effort to hire criterion. One noted that the framework for exemptions was likely to encourage the use of temporary staffing and that, given the cost of temporary labor, this may create a wrong impression while accelerating predatory temporary labor

pricing. Another comment recommended requiring facilities that intend to utilize a staffing exemption provide full disclosure of all financial documents, including ownership, related parties, profits, tax and corporate filings, audits, and financial statements and requiring that these documents be made available within 10 days of the request to residents, resident responsible parties, executors/trustees of resident estates, advocates, and regulatory agencies. One commenter suggested that in order to qualify for an exemption, a facility must demonstrate that its owners and management are not profiting from the nursing home or any company that is paid by the facility. Another stated that any exemption related to claimed financial constraints must be considered with far more robust transparency requirements. One commenter stated that the requirement is vague. In response to our question regarding a spending threshold, several commenters recommended that CMS establish that facilities must spend 80 percent of revenue on direct care services, similar to the proposed CMS requirements for HCBS services<sup>65</sup> and requirements in four States (New Jersey, New York, Massachusetts, and Pennsylvania). Another commenter recommended 75 percent as a threshold, with independent confirmation. One commenter stated that CMS must either conduct or direct the State survey agency to conduct an audit of the nursing home's finances.

*Response:* We thank commenters for these suggestions. We have considered both the comments supporting and the comments objecting to the financial commitment criterion. We recognize that the requirement we are finalizing only requires the facility to document and provide information when needed to receive an exemption. We believe that the financial commitment criterion will lead facilities to evaluate their financial commitment to staffing while leading CMS to better understand facility investment in staffing and the implications of expanding the requirement by establishing a threshold, requiring additional documentation, or other modifications. While we are not adopting these suggestions at this time, we will consider them for future rulemaking.

*Comment:* Some commenters specifically objected to the exemption determination being made after a facility is surveyed and determined to be out of compliance with the HRPD staffing

requirement. Several commenters indicated that being cited and fined before getting an exemption was unreasonable. One suggested that extensions of the exemption period should be automatic "if conditions persist." Many commenters felt that facilities should proactively be able to apply for an exemption through the submission of documentation. One commenter was concerned that the process requires facilities to open themselves up to additional scrutiny to qualify and that this could mean a provider opens themselves up to exclusion if a surveyor determines their insufficient staffing has resulted in harm or inaccurately cites the PBJ tag. Another commenter stated that facilities are already heavily penalized for not submitting PBJ data, and this exclusion should be limited to allow for a temporary lapse, especially when it results from emergent reasons, such as a disaster that the facility didn't report or when a facility is unable to submit data, despite trying, due to technical portal issues. One commenter noted that this would increase the workload on already over-burdened and underfunded State survey agencies. Others noted that States already have significant backlogs of surveys and facilities should not be penalized for that. One commenter recommended that CMS develop a streamlined process to apply for an exemption without requiring an onsite survey and noted that the exemption request process must be simple and not burdensome.

*Response:* We thank commenters for their feedback. We believe that the exemption criteria recognizes that some facilities may have difficulty meeting the new requirements and therefore may obtain an exemption if they meet the qualifications. However, this is balanced by the need to ensure residents' health and safety. With respect to a survey preceding the granting of an exemption, we note that facilities cannot request, and a State would not conduct, a survey specifically for the purpose of granting an exemption, but rather that facilities would be evaluated during a survey, such as the standard recertification survey, to determine if they were eligible for an exemption. A survey preceding any determination regarding an exemption would identify any other deficiencies of the facility, including those that could disqualify a facility from receiving an exemption and help ensure that safety and quality of care is maintained. As mentioned previously, we will publish more details on how compliance will be assessed after publication of this final rule in advance

<sup>65</sup> <https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicare-services-cms-2442-p-notice-proposed-rulemaking>.

of each implementation date for the different components of the rule. We intend to use the traditional process of communication of information via CMS QSO memoranda and publication of information in the State Operations Manual.

*Comment:* Some commenters recommended that specific types of LTC facilities be exempt from the HRPD requirements. One commenter recommended that Life Plan Communities (similar to Continuing Care Retirement Communities) be exempt. Some commenters suggested that all Tribal facilities be exempt from the HRPD requirements. Other commenters suggested that some specialized facilities (subacute units, hospital-based SNFs, and distinct part units of hospitals, any facility in an auto-HPSA) also be exempt from the HRPD requirements. One commenter recommended exempting nursing homes in States that have existing staffing ratio requirements for licensure. Others suggested that facilities with high quality measures at their current staffing levels be automatically exempted or be qualified to request an exemption. Some commenters said that they found the lack of flexibility, waiver, or leniency for communities taking good faith efforts to comply unfair. Finally, one commenter suggested that all rural facilities should be exempt.

*Response:* We thank commenters for these suggestions. As noted earlier, our goal is to promote safe, high-quality care for all residents. We also recognize the need to strike an appropriate balance that considers the current challenges some LTC facilities are experiencing, particularly in rural areas. We considered establishing categories for blanket exemptions, but are not adopting any at this time. Blanket exemptions for an entire category of facilities lacks the facility-specific assessment required under our proposal. In particular, we are finalizing a process under which any facility granted an exemption must have a preceding survey to determine its compliance with the requirements. However, such compliance determinations would not be conducted if we were to establish blanket exemptions. At this time, we want to ensure we are aware of any quality of care concerns at the individual facility level prior to granting an exemption. As we gain insight into facility compliance with the staffing minimums and in the application of the exemption process, we can consider suggestions to tighten the exemption process in future rulemaking. We note that hospital providers of long-term care

services (swing-beds) are not subject to the Nursing Services requirements under § 483.35, but instead are subject to the hospital conditions of participation, including staffing (§ 482.23), as well as specific provisions of 42 CFR part 483 identified in § 482.58.

*Comment:* Some commenters objected to using location as an exemption criterion, while others supported a location criterion. Many responded to our question regarding the “right distance” from another facility to warrant a hardship exemption, often suggesting an alternative or stating that mileage is not an indicator of hardship and objecting to any mileage-based criterion. One commenter stated that the mileage-based criterion was arbitrarily set and did not account for multiple facilities in the same area needing to apply for an exemption. Commenters noted a variety of BLS limitations, geographic features, and transit system considerations that made the location criteria problematic. Several commenters suggested that a provider to population ratio does not reflect the true availability of the workforce, and that this must be considered when determining eligibility for waivers and exemptions. One commenter supported the location criterion as proposed but wanted it to also be applied to the statutory waiver for RNs/licensed nurses; other commenters voiced similar concerns about the existing RN/licensed nurse waiver. Some commenters suggested removing the provider to population ratio, and reducing the mileage criteria to 10 or 15 miles. One commenter noted that the presence of a CAH near an LTC facility also impacted staff availability, even in the face of collaborative efforts. One commenter also suggested the mileage-based criterion be clarified for Tribal facilities to state that for Tribal facilities, it must be another Tribal facility within 20 miles. A different commenter suggested the mileage criterion should be 50 miles, stating that the average daily commute in the United States is 37 miles one-way (per U.S. Department of Transportation) and that it is not appropriate to jeopardize the health and welfare of a nursing facility resident with a staffing exemption for 20 miles when that is 17 miles less than the average commute of the staff who work at care facilities. Fifty miles was also suggested by another commenter who also felt the provider to population ratio should be changed to a more stringent 50 percent below the national average. Another supported 40 percent below the national average as the requirement.

Other commenters stated HPSA data is not a good criterion to determine exemption status, as the data only shows how many licensed nurses are in an area and does not consider how many of those nurses are willing to work in an LTC facility and that availability should take into consideration competition from other types of providers. One commenter pointed out problems with urban/rural definitions and further encouraged including urban facilities in eligibility for exemptions. Another commenter stated that the proposed method to determine a workforce shortage area is unworkable and inaccurate, because it is based on an already depressed national average. One commenter who objected to any exemptions stated that every nursing home resident deserved high-quality care, regardless of their geographic location or other factors. Many commenters who supported the need for staffing requirements also objected to exemptions, noting that all residents, regardless of zip code, are entitled to appropriate professional nursing care. One commenter recommended re-evaluating these criteria every six months and one year after implementation and annually.

*Response:* We thank commenters for these suggestions. We have considered the many perspectives and potential alternatives presented. Given that there was not a public consensus on the appropriate distance and considering the general opposition received in establishing this specific criterion, we have revised our proposal. We are only finalizing the applicable provider-population ratio for nursing workforce (RN, NA, or combined licensed nurse and nurse aide) in the facility area as a location criterion, removing the additional mileage-based criterion. As a threshold for determining a workforce shortage, given concerns raised about workforce unavailability, and in light of eliminating the distance criterion, we concluded that finalizing the moderate standard is appropriate. Therefore, we are finalizing that the provider-population ratio must be a minimum of 20 percent below the national average, as calculated by CMS, by using the Bureau of Labor Statistics and Census Bureau data.

*Comment:* One commenter objected to the use of the term “good faith effort” as too subjective and recommended that any term used must be objectively measurable. Several commenters were concerned with the term ‘prevailing wage’ and one suggested CMS should define the term “prevailing wage” in a manner that is more consistent with its use elsewhere in Federal law and

regulations. This commenter recommended looking to collectively bargained wage rates as a source of data on competitive wage levels, counting benefits as well as wages in the determination, and taking into account wage levels for jobs in other industries with similar entry requirements and for nursing positions in hospitals, staffing agencies, and other settings in determining the prevailing wage.

*Response:* We appreciate these comments and concerns. After considering all of the information and suggestions presented, we are finalizing the proposal regarding “good faith efforts” and “prevailing wages” as published. The language about prevailing wages is consistent with the statutory language in section 1919(b)(4)(C)(ii) of the Act in establishing requirements for facility waivers, which states that ‘the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.’ Therefore, we believe that the language used is appropriate. However, while we are not adopting these suggestions at this time, we may consider them for future rulemaking.

*Comment:* In response to CMS’s question about additional hardships that CMS should consider in providing exemptions, some commenters supported adding financial difficulties/constraints. Commenters noted that many facilities receive most of their revenue from Medicaid, which commenters characterized as inadequate in many States to cover the daily costs of care for the resident. According to commenters, these facilities would not be able to afford the increased staffing requirements and would most likely reduce the number of beds, lower the number of Medicaid residents they admit, or close, leaving many residents without housing because hospitals and other high-quality facilities may not admit residents who pose a high risk for negative outcomes. A commenter suggested that CMS provide exemptions based on financial hardship such as changes in financial performance as it relates to provision of care and services to residents, including financial exemptions based on customary accounting measurements such as changes in operating income, variances versus annual budget or prior year performance, and changes in cash flow. Others objected to a hardship exemption based on the financial condition of the provider. One commenter stated that we do not allow car manufacturers in

financial distress to produce vehicles without seatbelts or with less effective crumple zones in front-end bumpers; we do not allow airlines in financial distress to fly without stewards or qualified pilots and that adequate staffing should be a core element of any nursing home’s financial plans rather than an extra for those facilities that can afford it.

*Response:* We thank commenters for their concerns and suggestions. We have considered all of the information submitted and, given the competing nature of those comments and information, it would be challenging to define exactly what constitutes a financial challenge. Therefore, we are not at this time including an exemption criterion based on financial need but are maintaining a criterion based on a provider to population ratio. We note that facilities will be required to demonstrate through documentation the amount of financial resources that the facility expends on nurse staffing relative to revenue prior to being granted an exemption. While we are not adopting these suggestions at this time, we may consider them for future rulemaking.

*Comment:* Some commenters objected to the exclusion criterion for exemptions, either suggesting less restrictive or more restrictive exclusion criteria. A commenter stated that CMS should remove all the proposed exclusion criteria because all facilities should be afforded an opportunity for an exemption. Another commenter stated that facilities should not be required to be cited for staffing noncompliance before being eligible for an exemption and that facilities should be eligible to apply for an exemption based on the workforce supply and the facility’s good-faith efforts to hire and retain staff—no exceptions. Some commenters supported the exclusion criteria and one commended CMS for not considering HPRD exemptions for providers with a history of staffing concerns, poor care delivery, or harm or abuse to residents to whom they are entrusted to provide care. In response to our question about additional exclusions, some commenters felt CMS should expand exclusions to include Special Focus Facility Candidates (not just SFFs) and perennial 1-star rated facilities. Another suggested expanding the criteria that makes a facility ineligible for an exemption to include facilities that have recently been cited for failing to meet staffing standards and/or abuse or neglect of residents. A commenter suggested that CMS give States the option to tailor the exemption process to align with their existing

frameworks if those States have existing staffing standards and exemption. Another asked CMS to clearly indicate that the final rule will not preempt any higher State standards or State consumer protection and Medicaid Fraud Control Unit’s (“MFCUs”) efforts related to staffing or quality of nursing care in LTC facilities.

*Response:* CMS has considered these suggestions, balanced these noted concerns, and determined that, at this time, we will finalize our proposed exclusion criteria without modification. We note that it is a long-standing requirement that all facilities must comply with both State and Federal standards, and therefore, would be held to any higher standards imposed by a State.

*Comment:* One commenter specifically supported the 1-year time frame for exemptions. Many commenters noted that there are not enough surveyors or that surveys do not occur exactly 1 year apart.

*Response:* We thank commenters for their support and for voicing their concerns about the timing of surveys. In response, we are revising the timeframe for exemptions under § 483.35(h) from 1 year, to the next standard recertification survey. Thus, no matter when the exemption is initially approved following a survey, it is in effect until the next standard survey, unless it is removed as a result of a facility falling into the exclusion category. The exemption can be removed any time a facility develops any one of the exclusions. Waivers under §§ 483.35(f) (Medicaid nursing facilities) and 483.35(g) (Medicare skilled nursing facilities) are subject to annual review or renewal, respectively, pursuant to the waiver language set out in the Social Security Act.

*Final Rule Action:* After consideration of the comments, we received on the proposed rule, we are finalizing our proposal for hardship exemptions to the HRPD requirements with the following modifications:

- We have redesignated the proposed hardship exemption from the minimum hours per day requirements at § 483.35(g) as new paragraph (h) in this final rule and revised the heading to also include a hardship exemption from the “registered nurse onsite 24 hours per day, for 7 days a week requirements”.

- We have revised the location criteria at newly redesignated § 483.35(h)(1) (proposed § 483.35 (g)(1)) to eliminate the 20 mile criterion and remove all references to a 40 percent below national average provider-to-population ratio. We are finalizing at

newly redesignated § 483.35 (h)(1) (proposed § 483.35 (g)(1)) the requirement that the facility be located in an area where the supply of applicable healthcare staff (RN, or NA, or total nurse staffing) is not sufficient to meet area needs as evidenced by the applicable provider-to-population ratio for nursing workforce (RN, NA, or combined licensed nurse and nurse aide) that is a minimum of 20 percent below the national average, as calculated by CMS, by using the Bureau of Labor Statistics and Census Bureau data.

- We have modified the requirements at § 483.35(h)(1) to specify that a facility can receive an exemption from one, two, or all three of the following requirements, as follows:

(1) The facility may receive an exemption from the total nurse staffing requirement of 3.48 hours per resident day at § 483.35(b)(1) if the combined licensed nurse, which includes both RNs and LVN/LPNs, and nurse aide to population ratio in the area is a minimum of 20 percent below the national average.

(2) The facility may receive an exemption from the RN 0.55 hours per resident day requirement (§ 483.35(b)(1)(i)) and an exemption of 8 hours a day from the RN on site 24 hours per day, for 7 days a week requirement (§ 483.35(c)(1)) if the RN to population ratio in the area is a minimum of 20 percent below the national average.

(3) The facility may receive an exemption from the NA 2.45 hours per resident day requirement at § 483.35(b)(1)(ii) if the NA to population ratio in the area is a minimum of 20 percent below the national average.

- We have added new requirements at § 483.35(h)(4), *Disclosure of exemption status*, to require that the facility:

(1) Posts, in a prominent location in the facility, and in a form and manner accessible and understandable to residents, and resident representatives, a notice of the facility's exemption status, the extent to which the facility does not meet the minimum staffing requirements, and the timeframe during which the exemption applies; and

(2) Provides to each resident or resident representative, and to each prospective resident or resident representative, a notice of the facility's exemption status, including the extent to which the facility does not meet the staffing requirements, the timeframe during which the exemption applies, and a statement reminding residents of their rights to contact advocacy and oversight entities, as provided in the

notice provided to them at § 483.10(g)(4); and

(3) Sends a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

- We are not finalizing paragraph (g)(5)(iv) due to changes made to exemptions for the 24/7 RN requirement.

- We are finalizing, as proposed, requirements for good faith efforts to hire (§ 483.35(h)(2)) and demonstrated financial commitment (§ 483.35(h)(3)).

- We renumbered proposed paragraphs (g)(4) through (6) as paragraphs (h)(5) through (7) in the section accordingly.

- We have revised paragraph (h)(7) to provide that the term for a hardship exemption under § 483.35(h) is from grant of exemption until the next standard recertification survey, unless the facility becomes an Special Focus Facility, or is cited for widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm, is or cited at the immediate jeopardy level of severity with respect to insufficient staffing as determined by CMS, or fails to submit Payroll Based Journal data in accordance with § 483.70(p). A hardship exemption may be extended on each standard recertification survey, after the initial period, if the facility continues to meet the exemption criteria in § 483.35(h)(1) through (5), as determined by the Secretary.

## 6. Facility Assessment (Proposed § 483.71)

Facility assessments play an important role in ensuring that LTC facilities develop thoughtful, informed staffing plans to meet the needs of their specific residents based on case mix and other factors. The current requirements for the facility assessment are set forth at § 483.70(e) and require each LTC facility to conduct and document a facility-wide assessment to determine what resources are necessary to care for its resident population competently during both day-to-day operations and emergencies. It must be reviewed and updated annually, as necessary, and whenever the facility plans for or has any change in its facility or population that would require a substantial change to any part of the assessment. The assessment must address or include evaluation of the resident population, the facility's resources, and a facility-based and community-based risk assessment that utilizes the all-hazards approach. For the reasons set forth in the proposed rule, we proposed to redesignate (that is, relocate or move)

the existing requirements for the facility assessment to its own standalone section from § 483.70(e) to proposed § 483.71. We also proposed technical changes throughout the CFR to replace references to § 483.70(e) with § 483.71 based on this proposed change. We also proposed technical changes throughout the CFR to replace references to § 483.70(e) with § 483.71 based on this proposed change. For organizational purposes, we proposed to redesignate the stem statement for current § 483.70(e) to the stem statement for proposed § 483.71 and existing § 483.70(e)(1) through (3). We proposed to redesignate § 483.70(e)(1) through (3) as proposed § 483.71(a)(1) through (3), respectively.

At new § 483.71(a)(1)(ii), we proposed 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 proposed 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.

We also proposed to revise this paragraph to add "behavioral health issues" to clarify that LTC facilities must consider their residents' physical and behavioral health issues. At new § 483.71(a)(1)(iii), we proposed to add "and skill sets" so the requirement reads: "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 proposed 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 proposed 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.

We proposed 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).

In addition, we proposed a 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 proposed § 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 proposed 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. We did not propose to specify how the staffing plan should be developed or what it must contain. We solicited comments on the operational challenges or burdens of this proposed provision, as well as how CMS could best provide oversight of this proposed requirement.

We proposed at § 483.71(b)(5), to require facilities to use the facility assessment to inform contingency planning for events that do not necessarily require the activation of the facility's emergency plan but do have the potential to impact resident care.

Based upon our review and analysis of the comments, we are finalizing the proposed requirements as proposed with some revisions. The language we are finalizing and the reasons for those changes are detailed in the comments and responses below.

*Comment:* A few commenters supported the move to relocate the current requirements at § 483.70(c) (Facility assessment to a standalone) to § 483.71 (Facility assessment). However, other commenters opposed any changes to the current facility assessment requirements as unnecessary.

*Response:* We acknowledge that relocating the facility assessment requirements might not appear to be a substantial change. However, the facility assessment requirements are the foundation for any LTC facility's planning for the staffing and other resources that are necessary to provide the appropriate care required for its resident population. This merits a separate requirement and also emphasizes the importance of the

facility assessment. Hence, we are finalizing this redesignation as proposed.

*Comment:* Some commenters were supportive of the proposed changes to the facility assessment requirements. Several commenters were particularly supportive of the insertion of "behavioral health issues" in § 483.35(a)(1)(ii) in describing the factors the LTC facility's assessment must address regarding its resident population. One commenter even stated that the proposed changes to the facility assessment requirement were one of the most important changes that were proposed. However, there were also many commenters that opposed the proposed changes. Some commenters thought that the requirement was formulaic and many LTC facilities just "sleepwalked" through the process. Some opposed the proposed changes contending that they would only result in more paperwork and take direct care staff away from resident care. They contended that there was little, if any, evidence that the current requirements in any way benefitted residents, especially regarding nurse staffing. Other commenters noted that the facility assessment requirement has been essentially ignored by both LTC facilities and surveyors. They noted that from FY 2021 to FY 2023, there had only been 592 deficiencies cited regarding the facility assessment requirement and in only 10 of these cases was it even likely a financial penalty would be imposed. However, other commenters indicated that the proposed changes were not necessary because the vast majority of LTC facilities were already in substantial compliance with the current requirements.

*Response:* The comments received regarding facility assessment demonstrated a diversity of opinions on the proposed changes. We agree that the proposed changes will strengthen the overall facility assessment, which we have long viewed as a foundational element to care and resource planning in LTC facilities. The facility assessment is an important complement to the minimum staffing requirements finalized as part of this rule as it sets standards that must be met for staffing based on actual resident case-mix, not just the floor (baseline) created by the minimum staffing requirements. We agree with the commenters that the addition of "behavioral health issues" is an important change and emphasizes the need to consider these issues in the facility assessment. Thus, we are finalizing the addition of "and

behavioral health" at § 483.35(a)(1)(ii) as proposed.

However, we disagree with commenters about the meaning of the number of deficiencies cited by the surveyors. While the number of deficiencies is relatively low, this is not an indication that the requirement is being ignored or dismissed by the LTC facilities or surveyors. As some commenters indicated, the vast majority of LTC facilities are complying with the facility assessment requirement. Also, some surveyors might choose to cite a deficiency based on a requirement set out elsewhere in the LTC participation requirements instead of the facility assessment requirement. For example, a surveyor might cite a noncompliance deficiency for the sufficient nurse staffing requirement set forth at § 483.35(a)(1) rather than the facility assessment requirement. Regarding the commenters who opined that LTC facilities were only "sleepwalking" through the process, the governing body is responsible for the quality of care provided to residents and how the LTC facility's policies are established and implemented (§ 483.70(d)(a)). The medical director is responsible for the implementation of resident care policies; and the coordination of medical care in the facility (§ 483.70(h)). Hence, it is the responsibility of both the governing body and the medical director to ensure that requirements, including the facility assessment requirement, are complied with at their facility to ensure that residents receive quality, safe care. To address this concern, we are finalizing at § 483.71(b) a requirement that the LTC facility must ensure the active participation of a member of the governing body and the medical director in the facility assessment process. This is discussed in more detail below.

*Comment:* Many commenters supported the proposed facility assessment changes and recommended the requirement be strengthened. Some recommended that a tool be developed for LTC facilities to follow in conducting their facility assessments. Others recommended that LTC facilities could be required to follow a prescribed method or specific methodologies to provide some uniformity in the facility assessments and focus the assessments on resident acuity. They also suggested that the facility assessments should be reviewed and updated more often, such as quarterly. A few commenters recommended that the facility assessment either be included in or structured similarly to the quality assessment and program improvement (QAPI) program. Some others wanted to

require an evaluation of all of the training programs in the facility assessment process.

*Response:* CMS thanks the commenters for their recommendations. However, we will not finalize any of these recommendations as requirements in this rule. We will continue to evaluate these suggestions and consider these comments if there is future rulemaking regarding the facility assessment requirement. Regarding an evaluation of training programs in the facility assessment, at § 483.95 we require LTC facilities to develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. LTC facilities are required to determine the amount and type of training necessary based on their facility assessment as now set forth at new § 483.71. Hence, part of developing or reviewing and updating the facility assessment would include determining the amount of and type of training each individual providing services to residents should receive.

*Comment:* Several commenters were concerned about the proposed staff required to be involved in the facility assessment process, although many other commenters supported the idea that direct care staff should be closely involved in creating the facility assessments. Some commenters wanted to specifically name RNs and all other levels of nursing staff to ensure their input on staffing was included in the facility assessment. They contended that RNs were in the best position to determine staffing levels for the various units in the LTC facility. Other commenters contended that Nas should be specifically named since they provide most of the direct resident care. Some commenters were very supportive of our proposal because they believed the LTC facility's Medical Director should be actively involved in the facility assessment process. A few also suggested that the governing board be included in the process. However, other commenters opposed expanding the requirements for who should be involved in this process, especially in requiring non-staff or other third parties in the facility assessment process. Commenters contended that this would be inappropriate since it is an operational document for the facility. They suggested that the inclusion of third parties, especially union representatives, could be disruptive, divisive, and render the facility assessment ineffective. In addition, there are concerns that third parties,

especially union representatives, would not be primarily concerned about the residents' care and well-being but the workers they represent. Specifically, they raised their concerns that union representatives would be concerned with their members' compensation, benefits, and working conditions and not the care provided to residents. To address this concern, a few commenters recommended that any representatives of direct care workers also be an employee of the LTC facility. These commenters contended that only another employee would have the knowledge of the facility and its operations to provide beneficial input into the facility assessment. Other commenters noted that the guidance contained in the State Operation Manual that is used for surveys already indicates that LTC facilities should seek input from residents, resident representatives, resident families, and family councils.<sup>66</sup>

*Response:* The staff involved in the facility assessment are essential to the quality and comprehensiveness of the assessment. We agree with the commenters that all levels of the nursing staff need to be included in the facility assessment process so that the final product is comprehensive and provides the maximum benefit to the residents and the LTC facility. As discussed above, it is the governing body that is responsible for establishing and implementing the policies (§ 483.70(d)(a)) and the medical director is responsible for the implementation of that these individuals would also be essential to the facility assessment process. The most contentious comments generally regarded the proposal for representatives of direct care staff. We thank commenters for their suggestions. We agree the purpose of the facility assessment is to identify the resources and supports needed to safely care for residents. However, we also believe that individuals other than facility staff could offer beneficial input for the process. Input from the representatives of direct care staff, for example, third-party elected local union representatives, business agents, safety and health specialists, or a non-union worker's designated representatives from a worker advocacy group, community organization, local safety organization, or labor union, could be especially important. Direct care staff may be hesitant to criticize staffing

decisions of management or fear retaliation. Their representatives would generally be able to speak more freely and can reflect concerns that they have heard across a number of staff members. We agree that representatives who are not themselves employees may not have the knowledge of the facility or its operations as an employee would; however, it is the representatives' ability to provide input that employees might be hesitant to provide themselves that could be valuable input.

We want to clarify that the requirement for "direct care staff" means more than RNs, LPNs/LVNs, and Nas alone. We encourage LTC facilities to solicit input or even active participation from other direct care staff, especially physicians, nurse practitioners, physician assistants, social workers, activity directors, dietitians/nutritionists, and other therapists. Also, if the LTC facility has specialized units, such as, memory care, behavioral health, sub-acute, or ventilator/trach dependent, we encourage the inclusion or input of staff from those units. Due to the care provided by these specialized units, their staff could provide valuable input into the staffing and other resource requirements needed for the residents care for in units.

We also want to clarify our expectations regarding "active participation" for the staff identified in this requirement. LTC facilities need flexibility in how they conduct, develop, and implement their facility assessments. Hence, "active participation" does not require that all identified staff or their representatives are at every meeting or discussion or must approve the final facility assessment. However, at a minimum, all identified staff should have the opportunity to present their views and have those views considered by the other staff that are actively participating in the process. LTC facilities should determine the level of active participation for each individual thereafter. For example, if some meetings would focus on nurse staffing, the LTC facility would not necessarily have to require a physical therapist or a member of the food and nutrition staff to attend. Also, the LTC facility could limit the staff who would be responsible for the final approval of the facility assessment. In addition, individuals could participate in-person or virtually. For example, the medical director or member of the governing body could participate by phone in meetings or provide their input and comments on drafts in written form. Regarding those individuals whose input should be

<sup>66</sup> State Operations Manual, appendix PP Guidance to Surveyors for Long Term Care Facilities (Rev. 211, 02-03-23), Tag F838, Guidance sec. 483.70(e) (Rev.: 173, Issued: 11-22-17, Effective 11-28-17, Implementation: 11-28-17).



solicited and considered if received, the LTC facility should actively solicit input from identified participants. The LTC facility should determine the best way to contact these individuals to solicit their input. The input should then be shared with all of the individuals who are actively participating in the facility assessment process in time for there to be a discussion of the received input. The time period for providing input should be reasonable. The individuals from whom input is being sought would likely need more than a few days or a week to contemplate what input they want to provide.

Hence, we are revising § 483.71(b)(1) to require that the LTC facility require the active participation of the nursing home leadership and management including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and, direct care staff, including but not limited to, RNs, LPNs/LVNs, Nas, and representatives of direct care staff, if applicable. The LTC facility must also solicit and consider input received from residents, resident representatives, family members.

*Comment:* Some commenters contended that the proposed requirements conflicted with each other, especially the minimum nurse staffing and 24/7 RN requirements. They also noted concerns about how the facility assessment requirement worked with these requirements.

*Response:* All of the requirements in this finalized rule are designed to both function independently and work together to ensure that LTC facility residents receive the quality care required for their health and safety needs. The minimum nurse staffing requirement as set forth in § 483.35(a)(1) requires LTC facilities to have a minimum total nurse staffing of 3.48 HPRD with a minimum 0.55 HPRD for RNs, and a minimum total of 2.45 HPRD for Nas. Unless a LTC facility is exempted as described in § 483.35(h), each LTC facility must comply with the requirement. The 24/7 RN requirement is in addition to the minimum nurse staffing requirement; however, each RN that is on duty and providing direct resident care also counts towards both requirements. Hence, there is no conflict between these requirements. The facility assessment requirement as set forth at § 483.71 is a separate requirement that is designed to ensure that each LTC facility has assessed its resident population to determine the resources, including direct care staff, their competencies, and skill sets, the facility needs to provide the required resident care. If the facility assessment indicates

that a higher HPRD for either total nursing staff or an individual nursing category is necessary for “sufficient staffing”, the facility must comply with that determination to satisfy the requirement for sufficient staffing as set forth at § 483.35(a)(1). The facility assessment requirement ensures that each LTC facility assesses the needs of its resident population to determine the resources it needs to provide the care its residents require. However, if the facility assessment indicates that a lower HPRD or that a 24/7 RN is not required to care for their resident population, the LTC facility must still comply with those minimum staffing requirements. Hence, these requirements do not conflict with each other. Each requirement works independently to achieve the separate goals of a minimum nurse staffing requirement and an assessment of the resources that are required to care for the LTC facility’s resident population. They also work together to ensure that each LTC facility is providing the quality, safe care required for their resident population.

*Comment:* Some commenters questioned the usefulness of the facility assessment regarding determinations of daily staffing needs. They contended that the facility assessment is more global rather than granular, that is, it cannot assist with the daily changes in resident acuity.

*Response:* We acknowledge that resident acuity and daily staffing needs can vary. LTC facilities must already contend with and adjust for these changes daily. However, if the facility assessment was conducted according to the requirements finalized in this rule, LTC facilities should know the number of staff, the competencies, skills sets they need, and the other resources needed to care for residents in their facilities. This should enable LTC facilities to adjust their staffing and other resources to compensate for resident acuity and changes needed in daily staffing.

*Comment:* In the proposed rule, we discussed some of the reasons input from representatives of direct care representatives could be important for the facility assessment process. One statement was, “[a]longside direct care employees, their representatives *may also help ensure facility assessments are up-to-date and used to inform facility staffing*” (emphasis added) (88 FR 61375). Several commenters disagreed with the part of the statement emphasized in italics above. These commenters contended the enforcement role belongs exclusively to State and

Federal surveyors and is never the domain of a third-party representatives.

*Response:* We agree with the commenters that the enforcement of the LTC participation requirements is not within the scope of participation of third-party representatives. However, the referenced statement in the proposed rule located at 88 FR 61375 is not referring to any enforcement role. As stated in the proposed rule, the input from representatives of direct care workers could be beneficial, especially when the direct care workers are hesitant to raise concerns with their employers about the current staffing in the facility. In such instances, representatives can provide the LTC facility with assessments and recommendations anonymously from direct care workers free from the fear of retaliation, which could assist LTC facilities in ensuring their facility assessments are up to date and accurately inform facility staffing without retaliation. Ultimately, we believe that this type of input can positively impact staff leading to better and safer care for residents. Hence, we are finalizing a requirement that LTC facilities ensure the active participation of direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of direct care staff, if applicable.

*Comment:* Some commenters contended that the proposed changes constitute a one-size-fits-all approach that is inconsistent with the goals of the facility assessment. They contend that the individual needs of the residents and LTC facilities are not being considered or acknowledged in the proposed rule.

*Response:* We do not agree that these requirements utilize a “one-size-fits-all” approach. The minimum nurse staffing requirement as set forth in § 483.35(b)(1) requires LTC facilities to have a minimum total nurse staffing of 3.48 HPRD with a minimum 0.55 HPRD for RNs, and a minimum total of 2.45 HPRD for NAs. Because HPRD involves an assessment of the total number of hours worked by each type of staff compared to the actual number of residents in the facility, it is automatically adjusted for size of facility. With the facility assessment requirement, each individual LTC facility assesses its own resident population and the resources needed to care for them, which will often result in facilities needing to staff higher than the minimum staffing requirements. Thus, neither of these requirements is “one-size-fits-all” because they are tailored to each LTC facility. The only requirement that is the same regardless of the LTC facility or its

resident population is the 24/7 RN requirement. However, this requirement is designed to reduce the occurrence of preventable safety events for residents, as well as address health and quality concerns, which requires at least one RN providing direct resident care throughout the day. LTC facilities are expected to increase RN coverage as needed to comply with the minimum nurse staffing requirements and their facility assessment. The minimum nurse staffing and 24/7 RN requirements are not justifications for any LTC facility to fail to provide the direct care staff with the appropriate competencies and skill sets and other resources required to appropriately care for its resident population.

*Comment:* Some commenters were supportive of the requirement for certain individuals to be involved in the facility assessment process but recommended more time to comply with the requirement. These commenters noted that it would be difficult to assemble the staff required, develop the facility assessment, and a staffing plan in the usual time allotted after a final rule is published. One commenter recommended 120 days after the final rule was published, and another recommended two years.

*Response:* All LTC facilities should already have a facility assessment. While it should not take an extended period of time to do so, CMS is concerned that some LTC facilities might need more time to comply with the requirements finalized in this rule. For example, some LTC facilities might need additional time due to staffing issues or a lack of previous documentation. Hence, we are finalizing a longer implementation date for the facility assessment requirements in this rule to allow more time for LTC facilities to come into compliance. We proposed a 60-day implementation date for the facility assessment requirements, however, we are modifying our proposal to require implementation of the facility assessment requirements 90 days after publication of this final rule. LTC facilities should be using the facility assessment to determine appropriate staffing needs based on their resident population's care needs and meet these requirements in an accelerated manner.

*Comment:* Commenters were divided on the proposed requirement that set forth how LTC facilities were to use their facility assessments. Many commenters opined that additional requirements were unnecessary, burdensome, and would also be taking direct care staff away from resident care. There were also many commenters that were supportive, especially regarding

the requirement that the LTC facility use their facility assessment in making staffing decisions and in developing and implementing the staffing plan. One commenter was grateful that this section was clarifying how the facility assessment should be used and indicated that this made it more meaningful. Other commenters recommended that the requirement be strengthened to increase its effectiveness. Some commenters recommended a requirement for an assessment committee. Other commenters recommended a requirement on specific items that should be considered or included in the staffing plan, such as compensation and training for direct care staff.

*Response:* The new requirement at § 483.71(c) is intended to provide clarification on how LTC facilities are to use their facility assessments. While some commenters might argue that it is unnecessary, we disagree. The facility assessment is the foundation for LTC facilities to assess their resident population and determine the direct care staffing and other resources, to provide the required care to their residents. The facility assessment must be conducted and developed with the intent of using it to inform decision making, especially about staffing decisions. The facility assessment must be used to develop and maintain the staffing plan or the plan to maximize recruitment and retention of direct care staff. The facility assessment should identify the numbers of staff, types of staff, the required competencies and skill sets that staff require to care for the resident population. Thus, the facility assessment would inform the staffing plan the LTC facility requires. The facility assessment must also be used to inform contingency planning. LTC facilities will likely encounter different events that have the potential to affect resident care. These events, however, do not necessarily require activation of the facility's emergency plan. The facility assessment should be used to inform contingency planning to address these types of events. For example, direct care staff will call in sick some days. LTC facility must have contingency plans for when direct care staff cannot come into work. Hence, we are finalizing § 483.71(c) as proposed.

*Comment:* Some commenters opposed facility assessment requirements being used to cite for deficiencies during a survey. Commenters asserted that surveyors could not determine the quality of the facility assessment or the staffing plan. Also, they noted that even if the staffing plan was well developed, its effectiveness depended on so many

factors that LTC facility should not be responsible for any results.

*Response:* We agree with the commenters that surveyors cannot determine the quality of the facility assessment. Surveyors determine whether or not the LTC facility has complied with the facility assessment requirements as set forth in new § 483.71. Therefore, an LTC facility could be cited for non-compliance if its facility assessment failed to contain all the requirements set forth in new § 483.71 and failed to determine a direct care staffing plan consistent with facility resident acuity levels."

*Comment:* Some commenters were concerned about the potential of direct care staff, especially nurses, encountering retaliation as a result of participation in the facility assessment process. These staff might hesitate to criticize the LTC facility's staffing policies or make recommendations about staffing that they know will not be endorsed by the management. Some commenters recommended that nurses have some protections, such as whistleblower protections.

*Response:* RNs, LPNs/LVNs, and NAs are critical to a comprehensive and effective facility assessment. We encourage all direct care staff involved in the facility assessment process to provide thoughtful and honest feedback when participating in the facility review and development process for the assessment. Similarly, management should not punish or retaliate against direct care staff for providing honest input. In this rule, we are finalizing a requirement for facilities to ensure active participation from representatives of direct care staff, if applicable, as such we encourage staff, especially those who may be concerned about potential retaliation, to communicate with and utilize their representatives as a resource for sharing input. In addition, the Occupational Safety and Health Administration (OSHA) has resources to help employers learn about recommended practices to keep their workplaces free of illegal retaliation.<sup>67</sup>

*Final Rule Action:* We are finalizing as proposed the relocation of § 483.70(e) to a standalone section, § 483.71. We are finalizing as proposed the addition of "behavioral health issues" to § 483.71(a)(1)(ii); the addition of "and skill sets" to § 483.71(a)(1)(iii); and the addition of "as required" in § 483.73(a)(1) through (3). We are also finalizing our proposal to redesignate the stem statement for current § 483.70(e) to the stem statement for

<sup>67</sup> <https://www.osha.gov/sites/default/files/publications/OSHA3905.pdf>.

proposed § 483.71 and existing § 483.70(e)(1) through (3) as proposed § 483.71(a)(1) through (3), respectively. We are finalizing as revised § 483.71(b) to require that the LTC facility actively require the participation of the nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and, direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of direct care staff, if applicable. The LTC facility must also solicit and consider input received from residents, resident representatives, family members, and representatives of direct care staff. We are also finalizing as proposed § 483.71(c) that sets out the activities for which the LTC facility must use the facility assessment, including making staffing decisions, developing and maintaining a plan to maximize recruitment and retention of direct care staff, to inform contingency planning for events that do not necessarily require activation of the facility's emergency plan.

#### 7. Implementation Timeframe

We proposed to implement the 0.55 RN and 2.45 NA HPRD, the RN onsite 24 hours a day, 7 days a week, and facility assessment 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. This would give facilities significant time to recruit additional staff needed to meet the requirements.

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 changes in the Long-Term Care Survey Process system.

For facilities located in urban areas, we proposed that implementation of the final requirements be achieved in three phases, over a 3-year period. Specifically, we proposed 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 requirement of 0.55 and 2.45 HPRD for RNs and NAs respectively

(§ 483.35(a)(1)(i) and (ii)) 3 years after the publication date of the final rule.

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

Specifically, we proposed 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.

For purposes of the implementation timeframe, we proposed to define “rural” in accordance with the Census Bureau definition. “Rural” encompasses all population, housing, and territory not included within an urban area<sup>68</sup> We also solicited public comments on whether a different definition should be used. We noted that the final regulations would be effective 60 days following the publication of the final rule in the **Federal Register** and solicited public comments.

We received the following comments in response to this solicitation.

*Comment:* Many commenters supported a single implementation timeframe for both rural and urban LTC facilities. They expressed concerns that workforce shortages existed in both urban and rural areas regardless of facility location. One commenter stated that the separate phase-in timeframes would foster competition between urban and rural facilities, that nursing staff would be recruited away from rural areas to fulfill the needs of urban areas first, and when it became time for rural areas to recruit, they would find themselves competing to bring staff back. Many commenters noted that an extended implementation timeframe for rural areas would exacerbate existing disparities in the quality of care for rural residents. Moreover, commenters emphasized that residents in rural LTC facilities were entitled to the same quality of care as those in urban and underserved areas. Some commenters expressed concerns that the proposed

implementation timeframe favored rural areas as they would have not only an extended phase-in timeframe but also would be able to utilize the exemptions.

*Response:* We agree that residents in both urban and rural LTC facilities deserve access to safe and high-quality care and are finalizing for all LTC facilities, regardless of location, minimum nurse staffing standards along with a 24 hour per day, 7 day per week requirement for an RN to be onsite and available to provide resident care. We also agree with commenters that workforce shortages exist regardless of facility location, which is why we are finalizing exemption criteria that focus on the provider-to population ratio rather than on a facility's rural status alone. Equal access to exemptions from the requirements of this rule based on a pronounced unavailability of registered nurses and nurse aides will address this concern. We do not agree that a staggered implementation will result in potential employees being recruited away by facilities in urban areas, as there is no regulation that would prohibit any rural LTC facility from recruiting and retaining all nursing staff at any time, including those times when non-rural facilities are actively increasing their own staffing levels to comply with the requirements of this final rule. However, we recognize that there is a possibility that potential employees may opt to relocate if employers offer a more competitive salary. Additionally, all LTC facilities are required to comply with the facility assessment requirements at § 483.71 within the same timeframe, regardless of their location, effective 90 days after publication of this final rule. As part of the facility assessment, LTC facilities must develop and maintain a plan to maximize recruitment and retention of direct care staff.

We continue to recognize that rural areas face myriad challenges ranging from worker housing shortages to severe transportation challenges for remote facilities that are unique to their location. We are thus finalizing, in addition to an exemption framework, a staggered implementation timeline that allows additional time for rural facilities to comply with the requirements of this rule.

*Comment:* Many commenters expressed concerns that the proposed U.S. Census Bureau definition of “rural”, for purposes of the proposed implementation timeframe, does not accurately represent rural areas. In 2022, the U.S. Census Bureau published updated criteria on how it will define

<sup>68</sup> <https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html#:~:text=Rural%20encompasses%20all%20population%20housing,and%20for%20population%20density%20requirements>.

urban areas.<sup>69</sup> An urban area is comprised of a densely settled core of census blocks that meet minimum housing unit density and/or population density requirements. To qualify as an urban area, the territory identified according to criteria must encompass at least 2,000 housing units or have a population of at least 5,000 and rural consists of all territory, population, and housing units located outside urban areas.<sup>70</sup> Commenters expressed concern that the revised definition is too narrow, would exclude many areas that historically have qualified as rural or areas that fall under other Federal or State definitions of “rural” and that as a result, many LTC facilities in such areas would not qualify for the proposed extended implementation timeframe for rural areas. Numerous commenters suggested a wide variety of sources for alternative definitions of “rural” that CMS should consider using. A few commenters suggested aligning the definition of “rural” with other Medicare programs in order to promote consistency and assure access to services in rural communities that depend on LTC facilities for care delivery.

Specifically, these commenters suggested using the “rural” definitions from the Medicare Rural Hospital Flexibility Program, or the CMS–SNF–IRF wage index. Numerous other commenters suggested that CMS use an alternative definition that is used by other Federal programs and agencies. Commenters suggested these alternative definitions to address concerns that the current definition is not sufficiently accurate. Commenters suggested using definitions from the Office of Management and Budget (OMB),<sup>71</sup> or the Federal Office of Rural Health Policy (FORHP.)<sup>72</sup>

*Response:* We appreciate the varied comments received on the proposed “rural” definition. While most commenters did not support the use of the Census Bureau’s definition of “rural” and suggested using alternative definitions, there was not a consensus about which definition of “rural” would be most appropriate to use for the rule. However, we do acknowledge that using

the Census Bureau definition of “rural” for this rule could mean that counties that were considered rural prior to the Census Bureau updates in 2022 or under alternative Federal definitions such as the Office of Management and Budget (OMB), would now be considered urban. For example, if we were to use the Census Bureau’s definition of “urban”, 2,645 counties would be classified as urban,<sup>73</sup> while if we were to use OMB’s definition of “urban”, 1,252 counties would be considered “urban.”<sup>74</sup> Furthermore, the 2022 urban area delineations issued by U.S. Census Bureau removed the subcategories of urbanized areas (encompasses a population of 50,000 or more people) and urban clusters (encompasses a population of at least 2,500 and less than 50,000 people).<sup>75</sup> This means that towns as small as 5,000 people are delineated as urban areas with no differentiation between small towns and large cities.

We agree that the definition used in the rule should be consistent with the definition used in other Medicare programs and note that the definition of “rural” from OMB has been used by the critical access hospital requirements (see 42 CFR 485.610<sup>76</sup>), and rural emergency hospital requirements (see section 1886(d)(2)(D) of the Act<sup>77</sup> and 42 CFR 485.506<sup>78</sup>).

Based on the considerations of the comments and suggested alternatives, we are finalizing to define “rural” in accordance with the OMB definition. OMB designates counties as Metropolitan (metro), Micropolitan (micro), or neither. “A Metro area contains a core urban area of 50,000 or more population, and a Micro area contains an urban core of at least 10,000 (but less than 50,000) population. All counties that are not part of a Metropolitan Statistical Area (MSA) are considered rural.”<sup>79</sup>

<sup>69</sup> 87 FR 16706, March 24, 2022 (<https://www.federalregister.gov/documents/2022/03/24/2022-06180/urban-area-criteria-for-the-2020-census-final-criteria>).

<sup>70</sup> <https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html#:~:text=Rural%20encompasses%20all%20population%2C%20housingand%20For%20population%20density%20requirements>.

<sup>71</sup> <https://www.ruralhealthinfo.org/topics/what-is-rural>.

<sup>72</sup> <https://www.hhs.gov/guidance/document/defining-rural-population>.

<sup>73</sup> A list of all 2020 Census Urban Areas from the U.S., Puerto Rico, and Island Areas sorted by Urban Areas Census (UACE): <https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html>.

<sup>74</sup> Core Based Statistical Areas (CBSAs), Metropolitan Divisions, and Combined Statistical Areas (CSAs): <https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html>.

<sup>75</sup> <https://www.ruralhealthinfo.org/topics/what-is-rural>.

<sup>76</sup> <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F/section-485.610>.

<sup>77</sup> [https://www.ssa.gov/OP\\_Home/ssact/title18/1886.htm](https://www.ssa.gov/OP_Home/ssact/title18/1886.htm).

<sup>78</sup> <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-E>.

<sup>79</sup> <https://www.hhs.gov/guidance/document/defining-rural-population>.

*Comment:* Many commenters stated that the adoption of a final rule establishing minimum staffing in LTC facilities was essential. However, the commenters suggested various implementation timeframes. Many commenters recommended that CMS shorten the implementation timeframe to less than five years, with some suggesting that a shorter implementation timeframe would motivate facilities to begin recruiting and retaining staff to meet the finalized requirements as soon as possible. A commenter suggested that the LTC facilities would be able to meet the standards in a shorter phase-in because the proposed minimum nursing standards were relatively low and that the nursing staff needed would not need more than two hours of training.

Conversely, numerous other commenters suggested that CMS implement a phase-in timeframe of more than five years for all LTC facilities. One commenter expressed that the proposed phase-in timeframes did not allow sufficient time to recruit, train and graduate enough RNs due to the shortage of available seats in nursing schools. The commenter suggested that an unintended consequence of the proposed rule would be to force LTC facilities to hire nurses that might not be qualified and the LTC facilities would not have the time to train new staff “to ensure competency” and as a result, the LTC facilities would meet the minimum nursing requirement, but the residents would still be at risk due to the untrained staff. A commenter expressed that the additional time would allow facilities the time and financial support needed to “build out the necessary education and workforce infrastructure, so that hiring of the additional staff can happen.” Moreover, one commenter suggested that CMS delay the implementation timeframe of all LTC facilities “to at least 5 years after the date of the final rule, with an additional at least 36-month allowance period for facilities to hire staff once the workforce is available”.

*Response:* We agree with the commenters that the minimum staffing requirements are essential and are finalizing them with the revisions described in this rule. In determining the question of the appropriate timeline for implementing these changes, we sought to strike a balance between ensuring a higher level of resident safety through earlier implementation and assuring that the implementation of these changes is not so aggressive as to result in unintended facility closures or resident census reductions, both of which could negatively impact the

ability of residents to receive care in a location that is close to their loved ones. In addition to considering comments regarding the exact implementation timeframe, we also considered the totality of the many flexibilities that are included in this final rule, including finalization of the proposed exemptions to the NA and RN HPRD requirements, and the addition of exemptions for the total nurse 3.48 HPRD requirement and for the 24 hours per day, 7 days per week RN requirement. As such, we are finalizing the implementation timeframe as proposed for all non-rural LTC facilities to complete implementation 3 years after the publication date of this final rule and all rural facilities will complete implementation 5 years after the publication date of this final rule. We believe that this is the most appropriate approach to implementation in light of the conflicting public comments on the subject of the implementation timeframes, the many revisions that we have made to the policies within this rule, and our policy goal of improving the care of all LTC facility residents while avoiding unintended consequences. We strongly encourage all LTC facilities to begin working towards full compliance as quickly as possible.

*Comment:* Numerous commenters suggested that CMS outline interim milestones gradually increasing each year until LTC facilities meet the final RN and NA HPRD requirements. They stated that this approach would allow for LTC facilities to slowly adapt to the new minimum staffing requirements while continuing to provide safe and quality care. In addition, this approach would discourage last-minute hiring practices by LTC facilities.

*Response:* Taking into consideration conflicting comments, we have structured the implementation of the final policy discussed in this rule to occur in three phases; Phase 1 requires facilities to comply with the facility assessment requirements; Phase 2 requires facilities to comply with the requirement for a facility to provide 3.48 HPRD of nursing care and to have a RN onsite 24 hours a day, 7 days a week; and Phase 3 requires facilities to comply with the minimum staffing requirements of 0.55 and 2.45 HPRD for RNs and NAs respectively. We are phasing in the 3.48 HPRD total staffing requirements during Phase 2 as we expect LTC facilities will be able to comply quickly with this requirement since facilities may use any combination of nursing staffing types (RN, LPN/LVN, or NA), rather than using specific nursing staffing types to meet this requirement. However, we expect LTC facilities that are currently

staffing in excess of 3.48 HPRD of total nursing care will not reduce their total nurse staffing HPRD when the 3.48 HPRD for total nurse staffing requirement is implemented. LTC facilities should continue using the facility assessment to determine staffing needs above the finalized minimum standards to provide safe and quality care based on resident acuity.

Beyond these phases, we do not agree that it is appropriate to specify additional interim milestones. We believe that milestones should be specific to the needs of each facility and as part of the facility assessment, a LTC facility must have a facility-wide assessment to determine what resources are necessary to care for its residents. That assessment should consider, among other things, the facility's resident population, staff competencies and necessary skill set, its resources, and other factors that may affect the care it provides. The facility must use this facility assessment to inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for residents' needs and to develop and maintain a plan to maximize recruitment and retention of direct care staff. The facility assessment will drive the interim steps that need to occur at each facility in preparation for complying with the requirements of this final rule.

*Comment:* A commenter suggested that we delay the implementation of the requirements until CMS has completed a pilot program first.

*Response:* We appreciate this suggestion. However, we believe that the minimum staffing requirements need to be implemented as soon as possibly feasible to ensure residents receive safe and quality care in LTC facilities. Therefore, CMS will not proceed with a pilot program.

*Comment:* Commenters expressed that there is not a need for a longer implementation timeframe for other underserved communities, as there is no evidence available to show that LTC residents in underserved communities have lesser needs than LTC residents in other areas. They stated that it would only perpetuate poor quality care for underserved communities, especially among racial and ethnic minorities.

*Response:* We agree with the commenters. Residents in LTC facilities should have access to safe and quality care, regardless of location. Therefore, we are not extending the implementation timeline for medically underserved communities.

*Comment:* A commenter recommended that we consider ways to

incentivize nursing homes to meet the minimum nursing requirements on an accelerated timeline.

*Response:* In the FY 2023 SNF Prospective Payment System (PPS) Rule final rule (87 FR 47570 through 47576), we adopted the Total Nursing Hours per Resident Day Staffing (Total Nursing Staffing) measure for the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program—beginning with the FY 2026 program year. LTC facilities that have SNF beds participate in the SNF VBP Program and are subject to payment incentives under the program. Therefore, these LTC facilities will be incentivized to comply with the minimum staffing requirements because as their performance on the Total Nursing Staffing measure for the SNF VBP Program improves, those facilities may receive more favorable payment adjustments. Specifically, the LTC facilities that increase their staffing levels in FY 2025 and FY 2026 may receive either increased improvement or achievement scores under the SNF VBP Program. CMS awards achievement points to facilities that perform higher than the 25th percentile of national SNF performance on program measures and awards improvement points to facilities that have shown improvements in the measure performances from the baseline period to the performance period. Performance on the Total Nurse Staffing measure in the FY 2025 and FY 2026 performance year will affect payment adjustments in FY 2027 and FY 2028 program years respectively. LTC facilities that focus early on increasing their nurse staffing levels and otherwise improving performance on quality measures, such as the Total Nurse Staffing measure would have the opportunity to identify areas for further improvements and to take the necessary steps to address them. This could result in higher scores for the Total Nurse Staffing measure and subsequent increases in payment adjustments.

Regardless of these incentives, LTC facilities should use the facility assessment to determine appropriate staffing needs based on their resident population and their needs and meet these requirements in an accelerated manner to ensure timely and quality care to residents.

*Comment:* Some commenters recommended that we provide technical assistance to help LTC facilities meet the minimum staffing requirements within the proposed timeframe.

*Response:* As noted previously, CMS is launching an initiative to help increase the LTC workforce by committing over \$75 million in financial incentives, such as tuition

reimbursement, to support the recruitment, training, and retention of nursing staff.<sup>80</sup> CMS is also exploring the potential to provide technical assistance to LTC facilities through the Quality Improvement Organizations and additional opportunities to provide technical assistance to those facilities impacted by this final rule. CMS will release interpretative guidance following the publication of the rule ahead of each implementation phase.

*Comment:* A few commenters expressed that State governments must plan for and readjust funds in order to meet the increased expense that hiring staff will require. According to the commenters, currently most State Medicaid rates do not cover the daily cost of care for residents and will not be able to cover the increased cost of labor this minimum staffing requirement will incur. Commenters suggested working with State Medicaid officials and managed care plans to ensure appropriate reimbursement rates while a commenter recommended that we

establish advance funding for State governments.

*Response:* While the actions of State governments, including Medicaid rates, are not within the scope of this rule, we note that the policies in this rule will be phased in over a period of up to 5 years.

*Final Rule Action:* After consideration of the comments, we received on the proposed rule, we are finalizing the following implementation timeframe as follows:

- Rural facilities (as defined by OMB):
  - ++ The requirement related to the Facility assessment at § 483.71 must be completed 90-days after the publication date of this final rule.
  - ++ The requirement related to providing 3.48 HPRD for total nurse staffing at § 483.35(b)(1) and the requirement related to 24/7 onsite RN at § 483.35(c)(1) must be implemented 3 years after the publication date of this final rule.
  - ++ The requirements related to providing 0.55 RN and 2.45 NA HPRD

at § 483.35(b)(1)(i) and (ii) must be implemented 5 years after the publication date of this final rule.

- Non-rural facilities:

++ The requirement related to the Facility assessment at § 483.71 must be completed 90 days after the publication date of this final rule.

++ The requirement related to providing 3.48 HPRD for total nurse staffing at § 483.35(b)(1) and the requirement related to 24/7 onsite RN at § 483.35(c)(1) must be implemented 2 years after the publication date of this final rule.

++ The requirements related to providing 0.55 RN and 2.45 NA HPRD at § 483.35(b)(1)(i) and (ii) must be implemented 3 years after the publication date of this final rule.

These regulations are 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 3 and 4.

**Table 3: Implementation Timeframes for Facilities in Rural Areas**

Regulatory Section(s)	Implementation Date
§ 483.71	<i>Phase 1:</i> 90-days after the publication date of the final rule
§ 483.35(b)(1) and (c)(1)	<i>Phase 2:</i> 3 years after the publication date of the final rule
§ 483.35(b)(1)(i) and (ii)	<i>Phase 3:</i> 5 years after the publication date of the final rule

**Table 4: Implementation Timeframes for Facilities in Non-Rural Areas**

Regulatory Section(s)	Implementation Date
§ 483.71	<i>Phase 1:</i> 90-days after the publication date of the final rule
§ 483.35(b)(1) and (c)(1)	<i>Phase 2:</i> 2 years after the publication date of the final rule
§ 483.35(b)(1)(i) and (ii)	<i>Phase 3:</i> 3 years after the publication date of the final rule

### C. Severability Clause

Finally, we stated and continue to affirm that, to the extent a court may enjoin any part of the rule, the Department of Health and Human Services intends that other provisions or parts of provisions should remain in effect. Any provision of this final rule 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 final rule and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances. For instance, the specific HPRD and 24 hour, 7 day a week RN staffing requirements finalized at § 483.35(b)(1) and (c)(1) could independently make improvements in the number of staff present at a LTC facility—the continuity of any one of the numeric standards would be helpful, and they do not require enforcement of the others to improve conditions at LTC facilities. We also note that the Medicaid reporting provisions of this final rule regarding

the percent of payments spent on compensation for direct care and support staff workforce operate independently of mandated levels of nurse staffing—this is a reporting requirement, and the information about Medicaid expenditures on compensation for direct care and support staff workforce is important for CMS and the public in helping determine whether Medicaid service payments are economic and efficient, as well as adequate to support sufficient access for beneficiaries to high quality care.

<sup>80</sup> FACT SHEET: Biden-Harris Administration Takes Steps to Crack Down on Nursing Homes that Endanger Resident Safety | The White House:

<https://www.whitehouse.gov/briefing-room/statements-releases/2023/09/01/fact-sheet-biden->

[harris-administration-takes-steps-to-crack-down-on-nursing-homes-that-endanger-resident-safety/.](https://www.whitehouse.gov/briefing-room/statements-releases/2023/09/01/fact-sheet-biden-harris-administration-takes-steps-to-crack-down-on-nursing-homes-that-endanger-resident-safety/)

#### *D. 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. We held two listening sessions on June 27, 2022, and August 29, 2022, to allow all stakeholders, including State agencies and other organizations, to voice their concerns about the impact of a staffing standard, and took into consideration comments provided by State agencies.

Pursuant to section 1863 of the Act, in addition to publishing the proposed rule in order to solicit the views of States, we received comments from 11 State and local government organizations.

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

#### *A. General*

In response to concerns about transparency in the use of Medicaid payments and chronic understaffing in Medicaid institutional services (discussed in detail in our proposed rule at 88 FR 61381 through 61384), we proposed new Federal requirements to promote public transparency around States' statutory obligation under section 1902(a)(30)(A) of the Social Security Act (the Act) and around the quality requirements in section 1932(c) of the Act for services furnished through managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) under our authority under section 1902(a)(4) of the Act.<sup>81</sup> Specifically, we proposed to add new Federal requirements to promote better understanding and transparency related to the percentages of Medicaid payments for nursing facility and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services that are spent on compensation to direct care workers and support staff. As noted in 88 FR 61382, this proposal was specific to nursing facility and ICF/IID services, which we at times may refer to collectively in this preamble as "institutional services." We also noted in 88 FR 61382 that unlike in sections I. and II. of this rule, we will not be referring to LTC facilities, as this section (section III. of the final rule)

focuses on Medicaid-certified nursing facilities and ICFs/IID, which are not referred to as LTC facilities. As discussed in the proposed rule at 88 FR 61383, we relied on several sections of the Act for our authority to propose these reporting requirements. 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. 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 comply with such provisions as the Secretary may 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 proposed at § 442.43 to newly require that State Medicaid agencies report, at the facility level, on the percent of payments for nursing facility and ICF/IID services that are spent on compensation for the direct care and support staff workforce. While some States have voluntarily established similar transparency policies or initiatives, we noted our belief that a Federal requirement is necessary and would be more effective to generate more meaningful and comparable data and support transparency nationwide.

As discussed in our proposed rule at 88 FR 61384, we proposed that the reporting requirement at § 442.43 would apply not only to services provided under a fee for service (FFS) delivery system, but also when long-term services and supports (LTSS) systems are covered through managed care. For States that contract with MCOs and PIHPs to cover services delivered by nursing facilities and ICFs/IID, we proposed that States report annually on the percent of payments made to nursing facilities and ICFs/IID 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 MCOs. This includes services delivered by MCOs 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 proposed to apply the requirement to services delivered by PIHPs.

In addition, while we noted in the proposed rule at 88 FR 61383 that our proposal focused on institutional services, this proposal (which is being finalized in this rule) is consistent with efforts to address the sufficiency of payments for HCBS to direct care workers and access to and the quality of services received by beneficiaries of HCBS finalized in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**.

We received comments on our proposal. The following is a summary of these comments and our responses.

*Comment:* A number of commenters expressed broad support for the proposal to require States to report on the percent of Medicaid payments that nursing facilities and ICFs/IID are spending on compensation to direct care workers and support staff, and to make this information publicly available. Many of these commenters expressed concerns about low worker wages and chronic understaffing; a few commenters noted that low wages to institutional direct care workers and support staff have a disproportionate impact on women and people of color who make up a large proportion of this workforce. Many supportive commenters noted that collecting these data will help demonstrate the links between Medicaid payment rates, worker compensation, staffing levels, and quality of care. Commenters noted that more transparency and accountability in the use of Medicaid funds may address public mistrust of how facilities are spending Medicaid payments, empower beneficiaries to advocate for more investment in quality care, and ensure public resources are being allocated for adequate staffing levels, wages, and benefits.

A few commenters provided anecdotal examples of when facilities have received temporary or long-term rate increases, but the increases were not passed along to staff. A few commenters noted that while interested parties might cite low Medicaid payment rates as a barrier to fair compensation, there is inadequate evidence to support this statement due to the lack of transparent and uniform reporting on Medicaid payment rates; these commenters indicated that a reporting requirement could help clarify concerns regarding the sufficiency of Medicaid payment rates.

A few commenters noted that this information could be useful to

<sup>81</sup> Throughout this section, section III. of the final rule, the use of the term "managed care plan" means managed care organization (MCOs) and prepaid inpatient health plans (PIHPs).

researchers and policymakers. One commenter noted this proposal would create a better understanding around compensation differences across States, which will help to inform future policy improvements and help policymakers better understand where to target interventions for facilities that are outliers in terms of workforce compensation that may affect the quality and quantity of care provided to residents.

*Response:* We thank commenters for their support.

*Comment:* A number of commenters did not support finalizing the proposed reporting requirement, although many expressed general support for the principle of payment transparency. Many of these commenters indicated that the reporting requirement would pose an unreasonable burden on State Medicaid agencies and nursing facilities and ICFs/IDD. One commenter noted that the requirements might have a disproportionate negative impact on smaller facilities that have fewer streamlined administrative processes.

A number of commenters representing both nursing facilities and ICFs/IDD raised concerns that the proposal did not directly address Medicaid payment rates, which commenters believed are insufficient to support high-quality care or increases in direct care worker and support staff compensation; some of these commenters asked that we not finalize this proposal and instead propose requirements that States must regularly review Medicaid payment rates. Some of these commenters also suggested that without an increase in Medicaid payment rates to help offset the additional administrative burdens associated with reporting, facilities may have to redirect resources away from training and supervision, or some facilities may close.

A few commenters noted that the requirements as proposed, particularly the definition of direct care worker and reporting timeframes, do not align with current reporting requirements in the commenters' respective States. The commenters asked that we either not finalize the proposed provision or that we analyze existing State reporting requirements to ensure that any new Federal reporting requirements are not duplicative or misaligned with State reporting.

A few commenters representing ICFs/IDD suggested finalization of the proposed requirements be delayed until we take into consideration differences between ICFs/IDD and nursing facilities. These commenters stated that differences include variations in size, location, and physical layout; staff

responsibilities; and services offered to residents, including active treatment and community engagement. A few commenters suggested that ICFs/IDD should be exempted from the requirements if they are finalized.

*Response:* We acknowledge that complying with this reporting requirement will necessitate the use of resources and time on the part of providers and States. We believe that the value of the data collected through their efforts makes this use of resources and time worthwhile. As discussed further in this section, we are finalizing our definitions of compensation and direct care workers at § 442.43(a) with modifications to better account for the costs of clinical supervision, training, and other expenses that are essential to high-quality care. Additionally, as discussed further in this section, we are finalizing our proposal at § 442.43(b) to require only aggregated data reported at the facility level and by worker category (direct care worker or support staff), which we believe will limit burden on both providers and States.

We believe that, generally speaking, States and providers should already have information about the amount of Medicaid payments providers receive for specific services, and that providers likely already track expenditures for wages and benefits for their workers. We also believe that the aggregated reporting will be easier for States to validate and incorporate into their existing auditing processes.

While section 1902(a)(30)(A) of the Act does not provide us with authority to require specific payment rates or rate methodologies, section 1902(a)(30)(A) of the Act does provide us with authority to oversee that States assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan, at least to the extent that such care and services are available to the general population in the geographic area.

For managed care, section 1932(c)(1)(A)(ii) of the Act similarly does not speak explicitly to Medicaid provider payment rates but requires that States' quality strategies include an examination of other aspects of care and service directly related to the improvement of quality of care. Further, section 1932(c)(1)(A)(iii) of the Act authorizes the proposals being finalized in this section of this final rule, which enable States to compare payment data among managed care plans in their program; this could provide useful data to fulfill their statutory obligations for monitoring and evaluating quality and

appropriateness of care. This authority under section 1932(c)(1)(A)(ii) and (iii) of the Act is extended to PIHPs through our authority under section 1902(a)(4) of the Act.

We will be making the reporting methodology and reporting template for the requirements finalized at § 442.43 available for public comment through the Paperwork Reduction Act notice and comment process, which will give the public the opportunity to provide specific feedback and help us align the methodology and reporting process with existing State practices to the greatest extent possible. However, we acknowledge that because State processes, timelines, and definitions vary, it may not be possible to align all details of the reporting process with existing practices in multiple States. We therefore plan to provide technical assistance, as needed, to facilitate further alignment with States' current reporting practices, to the greatest extent possible.

We decline to exclude ICFs/IDD from the reporting requirement, as we do not believe such an exclusion would be warranted. We note that specific concerns related to ICF/IDD reporting are addressed throughout section III. of this final rule.

*Comment:* One commenter stated that we already collect multiple data sets that could be used to approximate the information that would be subject to the proposed reporting requirement, including: direct care salary, benefits, and hours for freestanding nursing facilities using the Medicare Cost Report; Medicaid fee-for-service per diems in upper payment limit reporting; and quarterly supplemental payment information through the Medicaid Budget and Expenditure Systems (MBES) and in CMS-64 reports. This commenter stated that we should use existing Federal data to approximate the proposed metrics, which the commenter believed would reduce administrative burden and ensure consistent calculations across Medicaid programs. A few commenters noted that facilities already complete cost reports and suggested that researchers and regulators interested in Medicaid expenditures could obtain spending information from these cost reports.

One commenter stated that Medicaid wage and benefit data are available in some States while Medicaid financial data are not available in other States; the commenter stated that while it would be ideal to have more detailed information on wages and benefits, the commenter did not believe that most State Medicaid programs would have this information available without developing a more



comprehensive financial reporting system.

*Response:* We disagree that these data are readily available from existing data sources currently collected by CMS. The data sources that the commenter listed would not provide information about Medicaid revenues at the facility level. We note, for instance, that the Medicare Cost Reports do not break out Medicaid revenues, nor are they completed by providers who do not bill Medicare. Other data sources cited by the commenters, such as the upper payment limit (UPL) reporting and quarterly supplemental payment information are data collection efforts related to provider payments that are intended for a different purpose and do not provide the information we intend to capture with the reporting requirement at § 442.43. We also note the supplemental payment reporting data does not capture the whole provider payment (that is, base plus supplemental payments). Additionally, the UPL reporting provides estimates of Medicaid payments to facilities; States have flexibility in how they calculate their UPL, using the best and most recent data available to the State either through Medicare cost reports or State-specific cost reports.

We also disagree that nationally comparable data could be extrapolated from current cost reports, given the variations among cost reporting forms, practices, and delivery systems. A number of States do not make cost reporting data readily available to the public in a way that facilitates easy analysis.

We agree with the commenter who observed that data are not consistently available from all States. As discussed throughout this section (section III. of the final rule), we have designed the requirement to promote greater consistency and transparency while also attempting to minimize burden for States, particularly those States with less experience collecting and tracking wage data, as well as for providers.

*Comment:* A few commenters did not believe that the reporting requirement as proposed would yield consistent or fully transparent data, given the differences among facilities, their payment models, current reporting practices, case mixes, size, geographical location, staffing requirements, and staff roles. A few commenters also noted that States have different wage laws that could impact the percent of Medicaid payments that facilities allocate to direct care worker and support staff compensation.

*Response:* We believe the diversity among facilities and State reporting

practices and employment laws is why a broad, national reporting requirement is necessary to help establish baseline data measuring investment in the direct care and support workforce. We note that the requirement is constructed so that States will report an aggregate percentage that will allow for national comparisons, as well as facility-level data that will allow for more granular differences among facilities to be identified.

*Comment:* A few commenters expressed concern that the reporting requirement would result in the generation of misleading data and perpetuate the idea that facilities' expenditures on any expenses other than direct care worker compensation are invalid or go only to profit. A few of these commenters suggested that facilities use Medicaid payments for a variety of expenses such as providing residents with private rooms, improving facility ventilation, evaluating and testing emergency preparedness plans, and other non-compensation activities that improve residents' care and safety. These commenters expressed concerns that reporting on the percent of Medicaid payments going only to compensation for direct care workers or support staff would lead policymakers to draw erroneous conclusions about facilities' expenditures and discourage increased investment in long-term care or the raising of Medicaid rates. One commenter expressed opposition to what they regarded as an underlying assumption that facilities are not allowed to be profitable.

*Response:* The purpose of this requirement is not to suggest that all non-compensation facility expenditures (including profits that may incentivize the operation of a facility) are invalid, or that any particular such expenditure is not worthwhile. Specifically, we are not suggesting that by designating certain activities as administrative and by not considering certain expenditures as compensation under this rule, they are inessential. Rather, we believe, as has been discussed at length in the proposed rule at 88 FR 61381 through 61382, that understaffing in facilities is well-documented and chronic and poses a risk to the quality of care. As a result, we have made addressing compensation for institutional direct care workers and support staff a particular focus of this requirement. We also remind commenters that the purpose of this rule is to create a reporting requirement, not to require that a certain amount of the Medicaid payment be allocated to compensation. We believe that gathering data on what percent of Medicaid payments facilities are spending on

compensation will help us understand what percent of Medicaid payments is also needed for non-compensation costs, which we understand includes many essential activities.

*Comment:* A few commenters expressed concerns that residents would not find the data helpful in making decisions about their long-term care and that beneficiaries and residents can already get valuable information about nursing facilities from Nursing Home Compare.

*Response:* We disagree that beneficiaries would not find the data helpful and note that some commenters expressed the contrary view that these data can help beneficiaries advocate for high-quality care. While we agree that Nursing Home Compare provides beneficiaries with useful information about nursing facilities, Nursing Home Compare does not include data on how much facilities spend on compensation to direct care workers and support staff.<sup>82</sup> We believe that facility-level data on the percent of Medicaid payments spent on direct care worker and support staff compensation will be a useful complement to the facility-level quality data in Nursing Home Compare and help make available more comprehensive information on nursing facilities for beneficiaries and other members of the public.

*Comment:* One commenter requested that this requirement be made a Condition of Participation for nursing facilities to encourage compliance and to allow the information to be included in Nursing Home Compare.

*Response:* We decline to make the reporting requirement a Condition of Participation at this time. We note that the provision being finalized at § 442.43 is a requirement that must be followed by States and does not directly impose requirements on providers. We believe it is important to first develop the reporting process and acclimate States and providers to this requirement before considering making it a Condition of Participation for providers, although we may consider proposing to do so at a later time.

*Comment:* A few commenters noted that the proposed requirement could help assess the extent to which facilities with a large Medicaid population have challenges achieving compliance with the minimum staffing standards finalized in section II. of this final rule.

*Response:* We agree that facility-level data reported by States could help

<sup>82</sup>To view what information is available on Nursing Home Compare, visit the Nursing Home Compare website at: <https://www.medicare.gov/care-compare/?redirect=true&providerType=NursingHome>.

identify facilities that are outliers in terms of allocating Medicaid payments for compensation for direct care workers and support staff, which could be relevant when examining understaffing or staff turnover at certain facilities. We also note that our intention with the reporting requirement at § 442.43 is to align with a similar reporting requirement focused on the percent of Medicaid payments for certain home and community-based services (HCBS) spent on compensation for direct care workers finalized in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**. These aligned requirements will provide a more consistent picture of compensation to the direct care workforce providing services to individuals receiving Medicaid-covered LTSS across settings.

*Comment:* One commenter asked that ICFs/IID be exempted from the minimum staffing standards.

*Response:* We clarify that while the provision at § 442.43 being finalized in this section (section III. of this final rule) applies to ICFs/IID, the minimum staffing standards being finalized in section II. of this final rule do not apply to ICFs/IID.

#### B. Definition of Compensation

At § 442.43(a)(1), we proposed to define compensation to include salary, wages, and other remuneration, as those terms are defined by the Fair Labor Standards Act (FLSA) 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 addition, we proposed 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 believed 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 were 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 requested 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 the proposed provisions.

We received comments on our proposal. The following is a summary of these comments and our responses.

*Comment:* Several commenters supported our definition of compensation.

*Response:* We thank the commenters for their support.

*Comment:* One commenter suggested that we align the definition with items normally reported on Internal Revenue Service (IRS) form W-2.

*Response:* We decline to make modifications to the proposed definition of compensation based on this comment. We believe the proposed definition encompasses the relevant compensation items that would be captured on a W-2 form, including the employee's salary, wages, other remuneration, benefits, and information about payroll taxes.

*Comment:* One commenter suggested we add differential pay and incentives to the definition of compensation.

*Response:* We are not certain what type of "incentives" the commenter was referring to. Our definition of compensation as proposed at § 442.43(a)(1) includes salary, wages, and other remuneration as defined by the FLSA and its regulations. The Department of Labor has advised that shift differential pay and nondiscretionary bonuses in health care settings are included within the definition of salary, wages, and other remuneration under the FLSA.<sup>83</sup> Non-discretionary bonuses<sup>84</sup> include those that are announced to employees to encourage them to work more steadily, rapidly or efficiently, and bonuses designed to encourage employees to remain with a facility.<sup>85</sup> Generally, we intended for the definition at § 442.43(a)(1) to include most types of payments made directly to direct care workers or support staff as salary, wages, and remuneration; we will provide technical assistance as needed for questions regarding specific types of payments.

<sup>83</sup> Refer to U.S. Department of Labor, Fact Sheet #54—The Health Care Industry and Calculating Overtime Pay. <https://www.dol.gov/agencies/whd/fact-sheets/54-healthcare-overtime>.

<sup>84</sup> The Department of Labor has advised that few bonuses are discretionary under the FLSA. *Id.*

<sup>85</sup> See regulations 29 CFR 778.200 and 778.208 for more information.

*Comment:* One commenter, while expressing support for the proposed definition of compensation, noted the importance of including medical, dental, and vision benefits, and retirement plans. A few commenters suggested we add paid leave and vacation time to the definition of compensation.

*Response:* We believe that all the items identified by these commenters—medical, dental and vision benefits, retirement, and paid time off—are either explicitly included in the proposed definition or would be reasonably considered part of benefits for the purpose of compensation.

In its glossary, the Bureau of Labor Statistics (BLS) defines compensation as "employer costs for wages, salaries, and employee benefits," and notes that the National Compensation Survey includes the following categories in employee benefits: insurance (life insurance, health benefits, short-term disability, and long-term disability insurance); paid leave (vacations, holidays, and sick leave); and retirement (defined benefit and defined contribution plans).<sup>86</sup> We believe the items suggested by the commenters align with our intent and are reflected by a common understanding of "benefits" as exemplified in the BLS glossary.

We are finalizing the definition of "benefits" at § 442.43(a)(1)(ii) with several modifications that we believe will help clarify what is included in the definition, will better align the definition with what is referenced in the BLS glossary, and will align this definition with a definition of compensation in a similar compensation reporting requirement finalized at § 441.311(e) as part of the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**. The purpose of aligning these requirements is to provide a more consistent picture of investment in the direct care workforce providing Medicaid-covered LTSS across settings.

We are retaining "health and dental benefits" but also adding to the list "life and disability insurance" to reflect the examples of insurance included in the BLS glossary. (We are using "disability insurance" to refer to short- or long-term disability insurance.) We note that the proposed definition at § 441.43(a)(1)(ii) already included health insurance, which we believe can be regarded as the same as medical benefits. The proposed definition also already included dental benefits. While we decline to specify vision benefits in this definition, which

<sup>86</sup> See BLS "Glossary" at <https://www.bls.gov/bls/glossary.htm>.

were not included in the proposal and is not part of the BLS glossary definition as a separate item from “health benefits,” we note that the list of benefits provided in § 442.43(a)(1)(ii) is not exhaustive, and that vision benefits, when offered by an employer, would reasonably be considered as part of compensation.

We are also changing “sick leave” to the broader term “paid leave,” as this should be understood to cover any time for which the employee is paid, whether it be for sick leave, holidays, vacations, and so forth. We are also adding retirement, which we believe is also a useful blanket term for different types of retirement plans or contributions on the employee’s behalf.

Thus, § 442.43(a)(1)(ii) as finalized in this final rule specifies that compensation includes benefits, such as health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement.

*Comment:* A few commenters, while not clearly requesting that these benefits be added to the definition of compensation, noted a number of benefits that employers may offer that may be difficult to quantify if they were to be included in reporting. These benefits included: recruitment and retention activities, gym fees, pet insurance, employee wellness programs, childcare support, nutrition programs, and assistance for staff experiencing financial shortfalls.

One commenter believed that including additional benefits in the definition of compensation would undermine the purpose of the requirement, which the commenter believed should focus on direct payments to workers.

*Response:* We are not making additional modifications to the benefits definition listed at § 442.43(a)(1)(ii) beyond what we described in the prior response. When proposing that benefits be included in the definition of compensation, we intentionally included the phrase “such as” when describing benefits to indicate that the example of benefits provided in the definition is not exhaustive. We did not attempt to list all possible benefits in the regulatory definition, as we run the risk of creating a definition that is too narrow.

However, we note that some of the items listed previously, such as employee wellness programs, which make available non-financial assistance to all employees (rather than being a specific financial benefit for the employee) would qualify as

administrative expenses.<sup>87</sup> We plan to provide technical assistance to States to help ensure that States understand what are considered administrative expenses versus compensation expenses.

*Comment:* A few commenters noted specific support for including the employer share of payroll taxes in the compensation definition, as this is also an important component of the full compensation cost. One commenter suggested that the definition should include worker’s compensation taxes.

*Response:* It is our intention to include employers’ payroll tax contributions for worker’s compensation (as well as other payments required by the Federal Insurance Compensation Act) under § 442.43(a)(1)(iii) (and thus as part of the definition of compensation). While not necessarily paid directly to the workers, these expenses are paid on their behalf. We also note, for instance, that per the BLS, the National Compensation Survey calls payroll taxes for worker’s compensation “legally mandated employee benefits” and includes them as part of the definition of “employee benefits” for the purposes of determining compensation.<sup>88</sup> We decline to make changes in this final rule based on these comments, but we plan to provide technical assistance to States on how to help ensure that providers are including payroll tax contributions for worker’s compensation, as well as contributions for other payroll taxes such as unemployment insurance, when reporting on compensation to workers.

*Comment:* A few commenters suggested that we add training costs to the definition of compensation, and a few commenters expressed specific concerns that the cost of specialized training for ICF/IID staff was not included in the definition of compensation. Commenters noted that training is a critical element of providing care.

In contrast, a commenter noted that attempting to disclose and quantify non-financial compensation forms would make reporting confusing and cumbersome and could lead to variations in reporting among States that would undermine the goal of uniform reporting. Another commenter agreed that we should not include training costs in the definition of compensation; the commenter noted that nursing

facilities are generally required to pay the costs for training required for certification of nurse aides but may then be reimbursed for the costs through a variety of payment methods or State grants. The commenter also noted that some facilities may choose to offer additional training as part of a collective bargaining agreement or to help reduce worker turnover, but did not believe the related costs should be considered part of the compensation package for workers.

A commenter asked that we add mileage reimbursement to cover the costs to deliver services in various locations.

*Response:* We clarify that the time direct care workers spend in training would already be accounted for in the definition of compensation. We agree with commenters that training is critical to the quality of services, and that some facilities, due to the needs of the residents, may require specialized training. We do not want to encourage providers to reduce training to cut administrative costs. We also agree that training costs may be difficult to standardize and are further complicated by the fact that some facilities may receive funding for training of some staff from sources other than their Medicaid payments.

We remain reluctant, upon considering comments, to treat all training costs as “compensation” to the direct care worker or support staff. Trainings are often required as part of the job and may vary depending on the services or the needs of the beneficiaries they serve. We are concerned that including training costs in the definition of compensation could mean that direct care workers with higher training requirements would see more of their “compensation” going to training expenses, which could cause them to be regarded as more highly compensated while receiving lower take-home pay than colleagues with fewer training requirements.

Rather than include training costs in the definition of “compensation,” we are creating a new § 442.43(a)(4) for the purposes of the reporting requirement in § 442.43 to define “excluded costs.” Excluded costs are those that are not included in the calculation of the percentage of Medicaid payments that is spent on compensation for direct care workers and support staff. We are specifying at § 442.43(a)(4)(i) that required training costs (such as costs for qualified trainers and training materials) reasonably associated with Medicaid-covered nursing facility or ICF/IID services are excluded from the calculation of the percent of Medicaid

<sup>87</sup> See 29 CFR 778.224(b) (describing various workplace perks which are not considered employee compensation when calculating overtime pay under the FLSA, such as the cost to an employer that provides gym memberships, wellness programs, or nutrition programs).

<sup>88</sup> See BLS “Glossary” at <https://www.bls.gov/bls/glossary.htm>.

payments to providers that is spent on compensation for direct care workers and support staff. This means that, unless providers receive payment for trainings from sources other than their Medicaid payments for nursing facility or ICF/IID services, providers could deduct the total eligible training expenses for direct care workers and support staff reasonably associated with delivering Medicaid-covered nursing facility or ICF/IID services from the provider's total Medicaid payments before the compensation percentage is determined. We note that in facilities that also serve residents whose services are covered by non-Medicaid payment sources, we expect that the facility would calculate the excluded costs by estimating the percent of total eligible training expenses reasonably associated with providing Medicaid-covered nursing facility or ICF/IID services, based on the percent of the facility's residents whose care is primarily paid for by Medicaid.

Similarly, we do not agree that mileage reimbursement or travel should be considered compensation to direct care workers and support staff. Since the reporting provision at § 442.43 pertains to facility-based services, we do not believe that travel expenses for direct care workers and support staff are necessarily high for a significant portion of facilities. However, we also acknowledge that there are reasons why facilities may need to require staff to travel as part of their duties, particularly in rural or smaller facilities or some ICFs/IID, which might require staff to transport beneficiaries to activities and appointments, assist beneficiaries in the community, or travel between facilities that are operated by the same provider. In these cases, the travel would not be for the direct care worker or support staff's personal benefit.<sup>89</sup> We also agree that travel costs will vary significantly by facility, depending on the facility size, staff makeup, nature of the services provided, and the beneficiaries served. We are concerned that including travel in the definition of compensation could mean that direct care workers or support staff with higher travel demands would see more of their compensation going to travel, which could cause them to be regarded as more highly compensated while receiving lower take-home pay than colleagues with lower travel demands.

To preserve beneficiary access to services (and access to the community

for facility residents) and avoid burden or disparate impact on beneficiaries, direct care workers, support staff, and providers in rural or underserved areas, we are excluding travel costs reasonably associated with providing Medicaid-covered nursing facility or ICF/IID services in this final rule from the calculation of the percent of Medicaid payments for nursing facility or ICF/IID services going to compensation for direct care workers and support staff. This means that providers could deduct the total eligible travel costs for direct care workers and support staff reasonably associated with delivering Medicaid-covered nursing facility or ICF/IID services from the provider's total Medicaid payments before the compensation percentage is determined. We note that in facilities that also serve residents whose services are covered by non-Medicaid payment sources, we expect that the facility would calculate the excluded costs by estimating the percent of total eligible travel expenses reasonably associated with providing Medicaid-covered nursing facility or ICF/IID services, based on the percent of the facility's residents whose care is primarily paid for by Medicaid.

To reflect the exclusion of travel costs from the payment calculation, we are adding a new § 442.43(a)(4)(ii) that specifies that travel costs for direct care workers and support staff (such as mileage reimbursements and public transportation subsidies) are considered an excluded cost for the purposes of the calculation at § 442.43(c).

We note that the finalization of excluded costs for training and travel at § 442.43(a)(4) aligns with the definition of excluded costs finalized at § 441.311(e)(1)(iii) as part of the Ensuring Access to Medicaid Services published elsewhere in this **Federal Register**. This definition also excludes training and travel costs from the calculation of the percentage of Medicaid payments for certain HCBS being spent on compensation for direct care workers. We reiterate that we believe alignment between these reporting provisions in §§ 442.311(e) and 442.43 is important to provide a more consistent picture of investment in the direct care workforce providing Medicaid-covered LTSS across settings.

*Comment:* While not necessarily asking that we account for personal protective equipment (PPE) in the reporting requirement, many commenters wrote about the importance of PPE in facility-based settings. Many of these commenters were self-identified direct care workers or other staff working in facilities and shared frustrations with not having sufficient

PPE during (and even after) the COVID-19 Public Health Emergency (PHE). A few of these commenters also noted specific concerns regarding administrative staff's access to PPE; one commenter, who self-identified as a receptionist in a nursing facility, shared an experience of being asked to interact with residents during the COVID-19 PHE without being provided PPE.

*Response:* We believe that these comments serve as an important reminder, especially given the recent experience with the COVID-19 PHE, that PPE should be treated as essential to supporting direct care workers and support staff's ability to perform their duties on par with training and travel. Providing direct care workers and support staff with adequate PPE is critical for the health and safety of both the workers and the beneficiaries they serve. We also do not believe that direct care workers or support staff should have to pay for PPE out-of-pocket or that it should be considered part of their compensation. We also note that due to the enclosed environment of many facilities, providing PPE to all staff is critical for maintaining health and safety for all staff and beneficiaries.

Similar to our approach with travel and training, we are also finalizing a new § 442.43(a)(4)(iii) to exclude costs for PPE reasonably associated with providing Medicaid-covered nursing facility or ICF/IID services. We note that this is consistent with an exclusion of PPE costs finalized at § 441.311(e)(1)(iii) in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**.

We are excluding PPE costs for facility staff reasonably associated with providing Medicaid-covered nursing facility or ICF/IID services in this final rule from the calculation of the percent of Medicaid payments for nursing facility or ICF/IID services going to compensation for direct care workers and support staff. This would mean that providers could deduct the total eligible PPE expenses for their facilities reasonably associated with delivering Medicaid-covered nursing facility or ICF/IID services from the provider's total Medicaid payments before the compensation percentage is determined. We note that in facilities that also serve residents whose services are covered by non-Medicaid payment sources, we expect that the facility would calculate the excluded costs by estimating the percent of total eligible PPE expenses reasonably associated with providing Medicaid-covered nursing facility or ICF/IID services, based on the percent of the facility's residents whose care is primarily paid for by Medicaid.

<sup>89</sup> See 29 U.S.C. 207(e)(2) (permitting employers to exclude "reasonable payments for traveling expenses" when determining an employee's regular rate of pay under the FLSA); see also 29 CFR 778.217 (same).

To reflect the exclusion of PPE costs from the payment calculation, we are adding a new § 442.43(a)(4)(iii) that specifies that a provider's PPE costs reasonably associated with providing Medicaid-covered nursing facility and ICF/IID services may be considered excluded costs for the purposes of the calculation at § 442.43(c).

After consideration of the comments, we are finalizing § 442.43(a)(1)(i) and (iii) as proposed. We are finalizing § 442.43(a)(1)(ii) with modifications to specify that compensation includes benefits, such as health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement.

We are also finalizing a new definition at § 442.43(a)(4) to define excluded costs, which are costs reasonably associated with delivering Medicaid-covered nursing facility or ICF/IID services that are not included in the calculation of the percentage of Medicaid payments that is spent on compensation for direct care workers and support staff. Such costs are limited to: costs of required trainings for direct care workers and support staff (such as costs for qualified trainers and training materials); travel costs for direct care workers and support staff (such as mileage reimbursement or public transportation subsidies); and costs of personal protective equipment for facility staff.

### *C. Definitions of Direct Care Workers and Support Staff*

At § 442.43(a)(2), for the purposes of the proposed reporting provision at § 442.43(b), we proposed 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, 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), 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 was intended to broadly define such workers to ensure that the definition appropriately captured the diversity of roles and titles that direct care workers may have. For the reasons discussed in the proposed rule (88 FR 61385), our proposed definition of direct care worker differs from the definition of direct care staff in LTC facilities at § 483.70(q)(1), which was established for the PBJ reporting program at § 483.70(q). We requested 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.

We requested feedback on our proposed definition of direct care worker at § 442.43(a)(2). We specifically requested whether there are categories of staff we should add to, or remove from, our proposed definition. We requested feedback from the public as to whether our proposed definition appropriately included workers who are instrumental in helping residents achieve the level of health or develop skills needed to transition from facility settings back into the community, assess residents for readiness for transition, and support in discharge planning, or if these workers should be included as a separate category.

At § 442.43(a)(3), for the purposes of the proposed reporting requirement at § 442.43(b), we proposed 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 was 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 proposed 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 requested comment on whether there are other specific types of workers, such

as security guards, who should be included in the definition. We also solicited comment on whether any of the types of workers listed in this proposal should be excluded from the definition of support staff. We also requested comment, generally, on our proposal to include support staff in this proposed reporting requirement.

We also proposed in both § 442.43(a)(2) and (3) to define direct care workers and support staff, respectively, to include individuals employed by or contracted or subcontracted with a Medicaid provider or State or local government agency. This proposal was 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. Additionally, a facility may contract with, for example, a third-party transportation company to provide transportation services to residents. We solicited 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 and support staff.

We received comments on our proposal. The following is a summary of these comments and our responses.

*Comment:* A few commenters expressed support for the definition of direct care worker. A commenter noted that the definition appears to capture most, if not all, positions that provide direct care to residents. Another commenter supported the definition because they believed it includes only the staff who provide direct care services to residents.

A commenter responded to our comment solicitation on using the definition of direct care staff at § 483.70(q)(1); this commenter did not support using the definition of direct care staff at § 483.70(q)(1) because it did not align with the duties and responsibilities of staff in ICFs/IID.

*Response:* We thank commenters for their support. With the exception of a few modifications noted later in this section, we are finalizing the definition of direct care worker that we proposed at § 442.43(a)(2).

*Comment:* A commenter noted that the examples of workers included in the direct care worker definition include

many workers who complement or supplement shortfalls in registered nurses and other long-term care staffing and contribute to the quality of care. This commenter supported the broad definition of direct care worker proposed at § 442.43(a)(2), and believed that for consistency throughout this final rule, these staff should count towards any minimum staffing requirement (which is discussed in section II. of this final rule). Another commenter requested that we clarify that the direct care worker definition at § 443.42(a)(2) is broader than that used in the proposed minimum staffing standard and therefore is for the purposes of this section only. A commenter expressed concern that this definition will lead some facilities to treat the workers included in this direct care worker definition interchangeably, such as asking skilled clinicians to perform unskilled services such as meal delivery or personal hygiene services. The commenter also raised a concern that some facilities might inappropriately substitute one type of clinical specialty for another if a broad direct care worker definition fails to recognize the unique clinical skills of each member of the multidisciplinary care team.

*Response:* We clarify that the definition proposed at § 442.43(a)(2) is only for the purposes of the reporting requirement being finalized in § 442.43 and is not to be used for the purposes of the minimum staffing requirements being finalized in section II. of this final rule. We also note that the intent of this requirement is to list the different staff whose compensation must be included in the numerator of the reported percent of Medicaid payments being spent on compensation. The intent is not to define a single category of interchangeable workers.

*Comment:* A commenter requested that we clarify that the definition excludes nurses who perform primarily administrative tasks. A commenter supported excluding administrative staff who are primarily in a supervisory position (such as a director of nursing) or primarily completing paperwork (such as nurses assigned to complete Minimum Data Set paperwork) and stated that the definition should include only the services of hands-on, direct care workers.

A commenter suggested we include physicians and physician assistants in the definition of direct care workers, given the importance of these staff to nursing facilities' patient care. A commenter stated that while they are not recommending we add physicians and physician assistants to the

definition, they would like to know the purpose of the data to understand why these roles were excluded. A few commenters also suggested we add pharmacists.

*Response:* Consistent with the proposed rule, our definition is intended to exclude staff who perform administrative tasks (such as overseeing business operations) and whose primary duty is to provide non-clinical supervision to other staff.

Upon further consideration, we are modifying our definition of direct care worker at § 442.43(a)(2) to clarify that the definition includes nurses or other staff providing clinical supervision. This modification is in recognition of the importance of clinical supervision in facility settings and to align with a similar modification made to the direct care worker definition finalized at § 441.311(e) in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**. (As noted in our proposed rule at 88 FR 61385, we believe it is important to keep the definitions of direct care workers in this rule and the Ensuring Access to Medicaid services rule as closely aligned as possible.) We clarify that nurses or other staff who provide clinical oversight and training for direct care staff (as allowed by their professional license), participate in activities directly related to provision of beneficiary care (such as completing or reviewing documentation of care), are qualified to provide services directly to beneficiaries, and periodically interact with beneficiaries should be included in the definition of direct care worker. In some instances, this may also pertain to physicians, physician assistants, or pharmacists that meet the elements of this description of nurses or other staff who provide clinical supervision. We decline to add physicians, physician assistants, or pharmacists as additional categories in the definition of direct care worker because we want to keep the definition focused on the staff that commonly provide most of the direct care in facilities.

We reiterate that our intention is to align the reporting requirement at § 442.43 with similar reporting requirements finalized in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**, which focuses on compensation rates for direct care workers providing Medicaid HCBS. The purpose of these aligned requirements is to provide a more consistent picture of the investment in the direct care workforce providing Medicaid-covered LTSS across settings.

*Comment:* One commenter requested clarification on whether Certified Medication Aides were included in the definition of direct care worker, and suggested we add this job duty if it was not included.

*Response:* We believe that a Certified Medication Aide would likely fall under the definition of direct care worker as proposed at § 442.43(a)(2)(vii), which specifies a medication assistant, aide, or technician. We note that job titles at facilities may vary, and States should apply their best judgment when determining if certain titles fit within the definition of direct care worker at § 442.43(a)(2). We will also supply technical assistance as needed.

*Comment:* A number of commenters representing ICFs/IID were concerned that Qualified Intellectual Disability Professionals (QIDPs) were not included in the definition. Commenters noted that, in addition to being a required position in ICFs/IID, QIDPs have specialized training and are responsible for care coordination and assessing, monitoring, documenting, and ensuring the provision of quality care to ICF/IID residents.

*Response:* We acknowledge that ICFs/IID are required at § 483.430(a) to be staffed by a QIDP, who may be doctors, nurses, or other professionals described at § 483.430 with specialized training in care for people with intellectual and developmental disabilities. It is our understanding that QIDPs' roles may vary in different States or even among different facilities within a State. For instance, some QIDPs may actively participate in direct care while others may take on more of an administrative or care coordination role. We note that the proposed definition of direct care worker included a broad category proposed at § 442.43(a)(2)(x) (but being finalized at § 442.43(a)(2)(xi), as discussed below), which specifies 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. We defer to States to determine if the QIDPs working in their ICFs/IID meet this definition or other elements of the definition of direct care worker at § 442.43(a)(2), and we have not added this position explicitly to the definition.

*Comment:* A number of commenters representing ICFs/IID expressed concern that Direct Support Professionals (DSPs) were not included in the definition of direct care worker. Commenters noted that in many States, "Direct Support

Professional” is a typical professional designation and a critical position in ICFs/IID; DSPs are often the staff that provide direct, daily support to ICF/IID residents. Commenters asked that we add DSPs to the definition of direct care worker at § 442.43(a)(2).

A few commenters noted that it may cause confusion to exclude DSPs from the definition of direct care worker in § 442.43(a)(2) when DSPs were included in the definition of direct care worker in the Ensuring Access to Medicaid Services rule (as the definition was proposed at 88 FR 27984). One commenter recommended we include DSPs in the definition at § 442.43(a)(2) to align the definitions in the two rules and acknowledge the role that DSPs play in providing LTSS care across settings.

*Response:* We are persuaded both by the characterization of DSPs as direct care workers and the concern that omitting DSPs in the definition of direct care worker at § 442.43(a)(2) would misalign the definition with the definition of direct care worker finalized in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**. We reiterate, as noted in prior responses, that our intention is to align the reporting requirement at § 442.43 with similar reporting requirements finalized in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**, which focuses on compensation rates for direct care workers providing HCBS. The purpose of these aligned requirements is to provide a more consistent picture of the direct care workforce for individuals receiving Medicaid-covered LTSS across settings.

After consideration of the commenters received, we are modifying the definition of direct care worker at § 442.43(a)(2) to include DSPs.

*Comment:* A few commenters responded to our comment solicitation regarding whether we should add to the definition 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. A commenter agreed that these staff duties should be added to the definition. Another commenter, however, stated that these staff should only be added to the definition if they are in a separate category from direct care workers. The commenter noted that these workers are providing important services to improve the residents’ health, safety, and autonomy, but the job duties vary much

more broadly than in the case of the direct care workers identified in § 442.43(a)(2).

*Response:* Based on the comments received, we are not modifying the definition of direct care staff at § 442.43(a)(2) to include a specific category of staff who provide transition supports. Although a few commenters were supportive of their inclusion as a separate category, we were not persuaded by the balance of the comments that staff who provide these supports are not already reflected in the different categories of workers contained in the definition. We also want to ensure that the definition focuses on workers who provide direct care, rather than what in some cases could be primarily administrative support.

We note that the proposed definition of direct care worker included a broad category at § 442.43(a)(2)(x) (being finalized at § 442.43(a)(2)(xi)), which specifies 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. We defer to States to determine if staff who provide discharge planning or other transition supports in facilities meet this definition or other elements of the definition of direct care worker at § 442.43(a)(2).

*Comment:* A number of commenters requested that we divide the definition of direct care worker into two categories: a direct care worker category and a category referred to as either “ancillary staff” or “licensed staff.”

One group of commenters advocated restricting the definition of direct care workers to nursing staff and recommended defining direct care workers as registered nurses, licensed practical nurses, and certified nursing assistants—a list they believed would align with the staff addressed by the minimum staffing requirements proposed in section II. of this final rule. Some of these commenters suggested this alignment would aid in interested parties’ ability to draw inferences from the data regarding the impact of the minimum staffing requirements proposed in section II. of this final rule. A few commenters suggested retaining nurse practitioners and clinical nurse specialists, in addition to registered nurses, licensed practical nurses, and certified nursing assistants. A commenter suggested that restricting the definition of direct care workers to nursing staff would aid in data

consistency among States because, while every facility employs nursing staff, there may be more variation among States and facilities in the types of the other workers; the commenter provided the example that some States recognize feeding and medication assistants, and others do not. Commenters who recommended limiting the definition of direct care worker to nursing staff suggested that a second category, “ancillary staff,” should be defined to include the other staff listed in § 442.43(a)(2) such as physical therapists, occupational therapists, speech-language pathologists, and therapy aides; some of these commenters also suggested adding physicians, physician assistants, and pharmacists to this category.

Other commenters advocated for limiting the definition of direct care workers to certified nursing assistants and, where relevant, personal care aides and home health aides. One of these commenters also suggested retaining feeding assistants in the definition. These commenters suggested that these roles are responsible for providing most of the direct care to nursing facility and ICF/IID residents, particularly in regard to activities of daily living. A few of these commenters suggested that these roles would align more closely with the definition of direct care worker in the Ensuring Access to Medicaid Services rule (as the definition was proposed at 88 FR 27984) and the way that the term direct care worker has been used by other Federal agencies such as the Administration for Community Living. Commenters also believed this would allow for the transparent reporting of compensation paid to workers who typically receive lower pay. Commenters expressed concerns that if compensation to these workers were reported together with the compensation paid to typically higher-paid workers, this would obscure the “unique contributions and challenges of these roles.” A few commenters suggested other staff listed in § 442.43(a)(2) should be included in an “ancillary staff” category. A commenter suggested that, rather than an ancillary staff category, we create a “licensed staff” category that includes all of the staff that typically require licensure.

*Response:* We decline to create a new category of ancillary or licensed staff apart from the direct care worker category. We note that there was not consensus among commenters that the definition of direct care workers should be limited to staff with nursing duties, staff without professional licenses, or staff who typically receive lower pay. We believe the category of direct care

workers as proposed at § 442.43(a)(2) is appropriately broad to capture a spectrum of workers who provide direct care to residents.

Limiting the definition of direct care workers to nursing staff does not align with our intention to examine expenditures for all staff who provide direct care to residents receiving Medicaid institutional LTSS. We also note that the reporting requirement we proposed (and are finalizing in this final rule) includes ICFs/IID, which do not necessarily focus on nursing services to the same extent as nursing facilities do. We agree with the commenter who noted that there might be variation in the types of non-nursing staff in nursing facilities, but we note that there is variety in the roles of *all* staff across facilities. Attempting to parse the direct care workforce into additional categories for reporting purposes not only adds administrative burden, it also could undermine our goal of creating simple, nationally comparable baseline data.

We continue to believe it is appropriate to include licensed professionals in the definition of direct care worker. There is a shortage of nurses and other clinicians delivering LTSS, and we believe it is important to support these members of the LTSS workforce especially, as they also work directly with residents. We disagree with commenters who stated that restricting the definition of direct care workers to certified nursing assistants, personal care aides, and feeding assistants would align the definition with the definition of direct care workers in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**. We note that the definition finalized at § 441.311(e), like the definition at § 442.43(a)(2), includes both licensed clinicians and other unlicensed direct care workers.

We also decline to add home health aides to the definition of direct care worker at § 442.43(a)(2). We agree with commenters that home health aides are part of the definition of direct care workers finalized in the reporting requirement at § 441.311(e) in the Ensuring Access to Medicaid Service final rule published elsewhere in this **Federal Register**. However, while we intend to align these definitions as much as possible to provide a complete picture of compensation for all direct care workers providing Medicaid LTSS, we also believe it is important to adapt each definition to their respective settings. We do not believe home health aides typically provide services in institutional facilities. In a situation

where care might be provided by someone described as a home health aide, we believe this role would be addressed by the category proposed at § 442.43(a)(2)(ix) (being finalized at § 442.43(a)(2)(xi)), which specifies inclusion of 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.

*Comment:* A number of commenters supported our definition of support staff and agreed that the definition was broad enough to include the workers responsible for supporting residents' health, safety, quality of care, and, in ICFs/IID, active treatment. A few commenters expressed specific support for including compensation for support staff in the reporting requirement.

*Response:* We thank commenters for their support.

*Comment:* A few commenters responded positively to our comment solicitation regarding the inclusion of security guards in the list of support staff, agreeing that these workers should be added to the list in § 442.43(a)(3). One commenter noted that some ICFs/IID that serve residents with aggressive behavior may be required to have security guards as part of their licensure.

Commenters suggested that we include the following workers in the definition of support staff: administrative staff (including billing staff); receptionists; information technology (IT) staff; central supply staff who purchase and distribute food, supplies, and materials for providers who maintain multiple facilities; staff who provide laundry or linen service; and transportation drivers.

A commenter noted that every employee who works in a facility contributes, in some way, to the care of those residents. The commenter stated that all persons contributing to the care of the residents, whether directly employed by the facility or through contract with an outside entity, should be included as either direct care or support staff.

*Response:* Based on feedback from commenters, we will modify the definition of support staff at § 442.43(a)(3) to include security guards. We believe that security guards provide important services that support the safety of staff and beneficiaries in facilities, but that these services may not intuitively fall under any of the other categories already included in the definition of support staff. Thus, we

believe it is important to explicitly include security guards as a category of worker included in the definition finalized at § 442.43(a)(3).

We decline to make other modifications to the definition based on comments. We believe laundry services are already included in the definition of support staff at § 442.43(a)(3)(i) as part of housekeeping duties, and thus, we decline to add that as a separate category in the definition. Transportation drivers are addressed in the proposed definition (and the definition we are finalizing) at § 442.43(a)(3)(v).

We believe the other specific positions described by commenters are administrative roles and would not be included in our definition of support staff at § 442.43(a)(3). We agree that all staff, including those who provide administrative support, are critical to the functioning of a facility. We also believe, as has been discussed at length in the proposed rule at 88 FR 61381 through 61383, that direct care worker understaffing in facilities is well-documented and chronic and poses a risk to the quality of care. As a result, we have made addressing compensation for institutional direct care workers and support staff a particular focus of this requirement.

*Comment:* A number of commenters, particularly those representing ICFs/IID, expressed concern that some staff may have duties that encompass components of both the direct care worker definition in § 442.43(a)(2) and the support staff definition in § 442.43(a)(3), such as DSPs who also provide services such as cooking, housekeeping, or maintaining the physical environment of an ICF/IID. Commenters expressed concern that this overlap in duties would create inconsistent reporting, confusion, or additional administrative burden if facilities had to report portions of the same staff's compensation in two categories. A commenter suggested we resolve this overlap by allowing the full compensation for these DSPs to be included in the direct care worker cost category.

One commenter also noted that the definitions of direct care worker and support staff do not address universal care workers who provide both nursing services and support services.

*Response:* We believe that for reporting purposes, compensation for staff that act as direct care workers and support staff should be reported according to the staff's primary job duties. We do not expect the calculations of the percent of payments for nursing facility and ICF/IID services that are spent on compensation for the



direct care and support staff workforce to allocate compensation across direct care and support staff categories based on the proportion of time an individual worker performs specific tasks.

*Comment:* A few commenters specifically noted support for the inclusion of third-party contracted and subcontracted staff in the definitions of direct care workers and support staff at § 442.43(a)(2) and (3). A commenter noted that if we were to exclude contracted staff from the reporting requirement, we would be missing critical information on staff compensation expenditures and create an incentive for facilities to rely even more heavily on contracted staff to avoid having to report on payments to these staff.

A few commenters suggested that we expand the definitions of direct care workers and support staff as they relate to the inclusion of third-party contracted staff. These commenters noted that nursing facility ownership structures have become extremely complicated and that organizations can engage with facilities in a variety of ways including complicated related-party transactions. These commenters recommended we expand the direct care worker and support staff definitions to include all individuals or entities providing services under contract, subcontract, or other related agreement, in whole or in part, with an organization or provider that provides goods or services to the facility through contract, subcontract, or other related agreement, in-whole or in-part. This includes direct care workers, ancillary services staff, and support staff providing goods or services to the facility under a contract, subcontract, or other related agreement, in-whole or in-part, and regardless of whether the individual receives a W-2 from either the contracted organization or the facility.

A few commenters observed that many facilities use contract labor (in which the contract price includes wages, benefits, and administrative costs) and all-inclusive contracts (in which a facility pays a monthly rate for labor, supplies, and other items). A commenter suggested that we modify the definition of compensation or benefits to clarify that the definition excludes any payment that is not directly received by the worker or excludes any payment that is retained by a related party or contracted agency. A commenter requested we issue guidance requiring facilities to report only the portion of contracted costs that are actually related to compensation; this commenter suggested that if it is not possible for facilities to report only the

portion of contracts related to compensation, that we require States to discount costs for payments to agencies and contractors by an amount that represents the average percentage of these payments that is not related to actual worker compensation, based on a State examination of a sample of such payments.

A number of commenters representing ICFs/IID noted that ICFs/IID often contract for many services. These commenters stated that obtaining compensation information from third-party organizations may be burdensome, might require obtaining confidential or proprietary information, discourage third party entities from contracting with ICFs/IID, create administrative burden and complexity, and open ICFs/IID to penalties if they are unable to track down this information. Some of these commenters specified concern about the impact of the requirement on ICFs/IID that contract with HCBS providers to allow the ICF/IID residents to attend community day programs. Relatedly, a few commenters noted that ICFs/IID may contract with other community organizations to provide ICF/IID residents access to, for example, YMCA programs, bowling alleys, or other recreational activities. These commenters were concerned that these community providers or organizations would not accept the ICF/IID residents if they were required to report on compensation to their staff. A few commenters expressed concern that States would reduce ICF/IID services or that ICFs/IID would stop offering community engagement activities or feel penalized for offering community engagement if presented with increased reporting burden.

To address the potential complexity of reporting on third-party contracted staff, a commenter suggested we allow the full cost of contracts to be reported separately, based on the general type of service being delivered, which the commenter believed aligns with most States' current ICF/IID cost reporting. Similarly, another commenter noted that in the commenter's State, Medicaid cost reports separate agency (contract) spending from compensation paid to employed workers and suggested that we adopt the same approach.

*Response:* We decline to modify the definitions of direct care worker or support staff in response to these comments. We agree that it is important to report on the compensation paid to contracted staff, not the value of the entire contract to a third-party. As noted by commenters, the value of the entire contract may include administrative or other costs that would fall outside the

definition of compensation and inflate the reported percentage of compensation. We also agree with commenters that excluding contracted staff would not provide accurate insight into allocation of Medicaid payments to the workers providing direct care and support to residents. We believe that the language in the definitions of direct care worker and support staff at § 442.43(a)(2) and (3) already indicates that it is compensation to workers employed as part of a contract, not the value of an entire contract for services, that should be included in the reporting.

We are concerned that some of the alternate language proposed by commenters might alter the definition in ways beyond what we intended for the definitions of direct care worker and support staff. For instance, we are uncertain what commenters meant in their proposed alternative definition by individuals who provide services "in-whole or in-part." If this is a reference to workers who provide services on less than a full-time basis, then we believe these individuals are already included in our definitions of direct care worker and support staff at § 442.43(a)(2) and (3), as these definitions do not specify whether a worker is employed on a part- or full-time basis. We are concerned that the language suggested by commenters could be interpreted as including compensation to individuals who, while supporting an organization that provides contracted services to residents, do not themselves provide services specifically for the residents.

We also note that the definitions of direct care workers and support staff that we proposed (and are finalizing, with modifications, in this final rule) are meant to capture employees and contracted staff who provide services, not goods, to facility residents. We would not, for instance, expect the compensation of staff working for a wholesale grocer that supplies food to a facility to be included in the reported compensation.

We acknowledge that some facilities may rely on a number of contracts to provide services for residents (including contracts with HCBS providers or other entities in the community). We do not believe the compensation of all workers employed by a contractor or subcontractor will be relevant to the reporting requirement. Given the variety of contracting models we will provide subregulatory guidance to States on how to approach reporting on compensation to contracted and subcontracted staff.

*Comment:* One commenter noted that HCBS providers providing contracted services for ICF/IID residents may face additional, duplicative, or conflicting

reporting requirements, due to finalization of compensation-related reporting requirements in the Ensuring Access to Medicaid Services rule.

*Response:* As finalized at § 441.311(e) in the Ensuring Access to Medicaid Services rule published elsewhere in this **Federal Register**, HCBS providers that provide homemaker, home health aide, personal care, or habilitation services will be required to report on the percent of Medicaid payments going to direct care worker compensation. We will provide subregulatory guidance on how States should approach reporting by HCBS providers who fall within the reporting requirement at § 441.311(e) and who also provide contracted services to nursing facility or ICF/IID residents to minimize reporting burden on these providers.

After consideration of the comments received, we are finalizing the definition of direct care worker at § 442.43(a)(2) with a modification to add DSPs and to include nurses or other staff who provide clinical supervision. We are finalizing the definition of support staff at § 442.43(a)(3) with a modification to add security guards.

#### D. Reporting Requirement

Based on our authority at 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 (that is, MCOs and PIHPs), we proposed 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. As noted in our responses previously, and as discussed in the proposed rule at 88 FR 61386, we believe that this information will help identify national trends and 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 will 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 proposed that the reporting to CMS would be for all Medicaid payments made to nursing facility and ICF/IID providers receiving payment

under FFS or managed care delivery systems. As discussed in 88 FR 61387, for FFS payments, this would include base payments and supplemental payments for nursing facility and ICF/IID services. 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.<sup>90</sup> We solicited comment on whether, for FFS payments, we should instead require 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 proposed at § 442.43(b) that, for States that contract with MCOs and/or PIHPs to cover services delivered by nursing facilities and/or ICFs/IID, States report on the percent of payments made by the MCO or PIHP to nursing facilities and ICFs/IID 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 also proposed to require that, if States deliver the relevant services through both FFS and managed care, the

States report separately for each delivery system.

We proposed that the reporting be performed annually. We solicited comment on this timeframe. We requested 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 received comments on our proposal. The following is a summary of these comments and our responses.

*Comment:* A number of commenters recommended that instead of, or in addition to, our proposed reporting requirements we implement the Medicaid transparency recommendations of the March 2023 Medicaid and CHIP Payment and Access Commission (MACPAC).<sup>91</sup> The MACPAC recommendations call for State Medicaid programs to make nursing facility payment and cost data publicly available for each nursing facility in a standard format that includes: (1) FFS base Medicaid payments, FFS supplemental payments, managed care State directed payments, and beneficiary contributions to their share of costs; (2) the amount of provider contributions to the non-Federal share of Medicaid payments to calculate net payments to providers; (3) expenses for wages and benefits separately for nursing, ancillary, and support services as well as administrative staff and other employees; (4) expenses for direct care including staffing costs for nursing, ancillary, and support services; (5) expenses for administration, property, and profits; and (6) detailed expenses for related-party transactions, real estate ownership, and disallowed costs. These commenters believed that unless Medicaid programs are required to provide more comprehensive data on rates and payments as well as expenses, we will not be able to draw any useful conclusions from the proposed transparency requirement.

*Response:* We defer to States as to whether they wish to make this information available to the public. While we agree that this level of granular detail would generate a great deal of potentially useful information, we strongly disagree with commenters that reporting on higher-level aggregated data would not yield useful information. We note that the reporting requirement at § 442.43 will provide data on the

<sup>90</sup> 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>.

<sup>91</sup> Medicaid and CHIP Advisory Committee, *March 2023 Report to Congress on Medicaid and CHIP*. See specifically "Chapter 2: Principles for Assessing Medicaid Nursing Facility Payment Policy." Available at: <https://www.macpac.gov/publication/principles-for-assessing-medicaid-nursing-facility-payment-policies/>.

percent of Medicaid payments (including FFS base payments, FFS supplemental payments, managed care State directed payments, and beneficiary contributions) that is being spent on compensation for direct care and support staff as well as other payments that may not all be captured in the MACPAC recommendations, such as other payments in managed care delivery systems, including contractually negotiated rates, pass-through payments, and any other payments from the MCO or PIHP in managed care delivery systems. As noted in a prior response, we decline to subdivide direct care workers into nursing and ancillary staff categories. We believe that this reporting requirement will result in nationally comparable baseline data that will allow for inferences regarding investment in the direct care and support staff workforce. While we will take the other recommendations under consideration, at this time we do not intend to increase administrative burden on States and providers by requiring Federal reporting on additional categories that fall outside of our focus on the direct care and support staff workforce.

We also point commenters to the Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities final rule (88 FR 80141) published on November 17, 2023, which implements portions of section 6101 of the Patient Protection and Affordable Care Act requiring the disclosure of certain ownership, managerial, and other information regarding Medicare skilled nursing facilities (SNFs) and Medicaid nursing facilities. Some of the commenters' additional concerns regarding facility ownership structures may be addressed by the requirements in that rule.

*Comment:* A few commenters noted support for requiring reporting of both FFS base and supplemental payments, pointing out that supplemental payments contribute to total revenue in the same way that base rates do and should not be treated differently or excluded.

One commenter noted that in the commenter's State, facilities do not receive FFS supplemental payments but rather receive varying FFS base payments depending on the acuity of the residents. This commenter stated that requiring reporting on total payments would result in better comparisons across States. A few commenters stated that FFS payment base rates do not fluctuate drastically year-to-year without changes to the

State plan, and thus believed that including both FFS base and supplemental payments would not be burdensome and would provide a comprehensive picture of nursing facilities' expenditures on compensation. A few commenters also noted support for requiring reporting on all payments from an MCO or PIHP, including State directed payments made by these managed care plans.

One commenter, on the other hand, supported reporting on FFS base and supplemental payments separately. The commenter stated that separate reporting would illustrate the separate roles of the FFS base payment and supplemental payments, which in turn would be important to understanding how Medicaid payments support nursing facility staffing and ensure supplemental payments were also being used to support worker compensation.

*Response:* We are finalizing the substantive language at § 442.43(b) specifically requiring reporting on Medicaid FFS base and supplemental payments as proposed. (We note that we are finalizing § 442.43(b) with some non-substantive technical modifications to improve the overall clarity of the requirement.) We agree with commenters that requiring reporting on both Medicaid FFS base and supplemental payments (added together) strikes the right balance of providing a complete picture of Medicaid FFS payments while minimizing administrative burden to the greatest extent possible.

Upon further consideration, we are finalizing § 442.43(b) with a modification to remove the specification that reporting is "by delivery system." We continue to expect that services delivered under a managed care delivery system will be part of the reporting requirement. We do not, however, intend to require that States report data to us separately by delivery system. We note that commenters did not express specific support for this separate reporting, and we are concerned that this separate reporting may increase administrative burden in States that provide services through both FFS and managed care delivery systems. We also note that the compensation reporting requirement (reporting on the percent of Medicaid payments made to direct care workers providing Medicaid HCBS) finalized at § 441.311(e) in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register** does not require separate reporting by delivery system. We intend to align these reporting requirements to the greatest extent possible.

*Comment:* A commenter requested that CMS clarify what payments are required to be reported in accordance with § 442.43(b) for providers that are network providers for an MCO or PIHP.

*Response:* We point readers to the language being finalized at § 442.43(b), which states that the Medicaid payments that must be included in the State reporting include the contractually negotiated rate, State directed payments, pass-through payments, and any other payments from the MCO or PIHP for nursing facility and ICF/IID providers.

*Comment:* Several commenters supported requiring reporting at least annually for both FFS and managed care delivery systems, which commenters believed would aid in tracking trends in worker compensation across facilities and States. One commenter noted that an annual frequency appropriately balances the need for actionable information with administrative burden. One commenter noted that timely data on Medicaid is critical as rates can be too low and not updated frequently, which can have a negative impact on providers and on beneficiaries' access to care. One commenter noted that frequent public reporting can be a critical element to promoting policy change and improving health care quality.

A few commenters, however, while stating that they found the annual reporting frequency to be reasonable, noted that States have many reporting burdens and asked that we remain receptive to alternative frequencies proposed by States. One of these commenters noted that some States may need more time than others to come into compliance with the requirement and suggested that we allow for some flexibility to accommodate different States' circumstances or allow States to determine their own timeframe.

A few commenters, citing concerns about the burden associated with collecting and analyzing reimbursement streams and worker compensation data, as well as competing reporting priorities and limited staff resources, suggested we require reporting every 3 years. One of these commenters noted that some of the wage and benefit information that would be required is not readily available to some Medicaid agencies, not all cost reports have this information, and providers do not typically report this type of information to their State Medicaid agencies.

*Response:* We are finalizing the annual reporting frequency as proposed. We agree with commenters that receiving timely reporting data is critical, and we are concerned that if too much time elapses between each

reporting period, the reports, when released, will become quickly out of date. Additionally, as discussed further in this section, we are finalizing at § 442.43(f) an applicability date that will give States 4 years to comply with this reporting requirement. Once States that do not currently collect these data update their systems appropriately, we believe the reporting will become routine and the initial administrative burden will lessen. We will provide technical assistance to States as needed as they develop their reporting capacity.

After consideration of the comments received, we are finalizing a modification to § 442.43(b) to strike “by delivery system” from the reporting requirement.

We are also finalizing § 442.43(b) with minor modifications to clarify that the Medicaid payments used in the calculation required at § 442.43(b) do not include excluded costs (which are being finalized at § 442.43(a)(4), as discussed in section III.B. of this final rule.) Additionally, we are finalizing the regulatory text at § 442.43(b) with technical modifications to aid with clarity and correct minor grammatical errors.

#### *E. Exclusion of Certain Payments*

We proposed at § 442.43(b)(1) to require reporting for payments, including FFS base and FFS supplemental payments, and payments from managed care plans, to nursing facilities and ICFs/IID for Medicaid-covered services, with the exception of services offered in swing bed hospitals (as described in § 440.40(a)(1)(ii)(B)). We proposed 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 solicited comment on this proposal.

For reasons discussed in the proposed rule at 88 FR 61387, at § 442.43(b)(2), we proposed that States exclude from the reporting payments for which Medicaid is not the primary payer, meaning that States would exclude payments for services for residents who are dually eligible for Medicare and Medicaid and whose skilled nursing care services are paid for by Medicare. We solicited 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 requested comment on whether excluding cost-sharing payments would increase or decrease burden on States and providers.

For reasons discussed at 88 FR 61387, we did not propose to exclude beneficiary contributions to their care when Medicaid is the primary payer of the services.

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 were concerned that such an option could discourage providers from serving Medicaid beneficiaries or increasing the number of Medicaid beneficiaries served. We requested 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 requested 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).

We received comments on our proposal. The following is a summary of these comments and our responses.

*Comment:* A few commenters supported our decision to exclude payments to swing beds from the reporting in the proposed rule. These commenters noted that swing bed hospitals utilize different accounting systems for their expenditures and thus should not be included in nursing facility reporting. One commenter agreed that swing bed hospitals should be excluded to avoid placing a burden on rural facilities that serve a relatively low number of nursing facility residents.

*Response:* We thank commenters for their support. We are finalizing the exclusion of payments to swing bed hospitals at § 442.43(b)(1) as proposed.

*Comment:* A few commenters agreed with excluding payments for services in which Medicaid is not the primary payor. One commenter specifically agreed that this exclusion would reduce burden on States and providers and that payments from other payors would not provide meaningful insight into the allocation of Medicaid payments for compensation of workers. However, a number of commenters recommended we require that reporting be for the percent of all revenue spent on compensation (and not limited just to the percent of Medicaid payments). Commenters believed this would further aid in transparency and oversight of how facilities allocate their revenue. A few commenters also stated that requiring only reporting on payments for which Medicaid is the primary payer actually increases burden and recommended that reporting be on the percentage of all revenues that are spent on compensation. Commenters noted that nursing facilities receive revenue from many sources apart from Medicaid payments and pay direct care workers and support staff compensation from a pool comprised of all revenue sources.

A number of commenters recommended we expand this requirement to include Medicare as well as Medicaid payments. A few of these commenters disagreed with our statement that including Medicare payments was out of scope. These commenters stated that not only is including Medicare payments within our authority, not doing so ignores our legal obligations under the Nursing Home Reform Act (specifically, 42 U.S.C. 1396r(f)(1)) to protect residents and make sure that public funding is effectively and efficiently used, as well as our obligations under section 6104 of the Affordable Care Act (requiring that skilled nursing facilities receiving Medicare payments disclose wages paid to direct care staff on their cost reports).

*Response:* We decline to modify the requirements to require reporting for all revenue or for Medicare revenue, as this would be out of scope for the proposal. We believe that States and facilities are aware of the amount of Medicaid payments received by each facility. We understand that all revenue received by a facility ultimately gets pooled together for the purposes of paying worker compensation and that facilities often serve a mix of residents with different payers and different needs. As discussed further in this section, we will provide a methodology that will allow States to make a reasonable calculation of what percent of a facility’s direct care and support staff

workforce was paid from Medicaid revenues.

As discussed in the proposed rule at 88 FR 61383, we proposed these reporting requirements in part using our authority under section 1902(a)(30)(A) of the Act, which 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. We believe section 1902(a)(30)(A) of the Act speaks specifically to Medicaid payments, not to all payments received by providers. We will take under advisement commenters' recommendations regarding reporting on all revenue but cannot pursue such a requirement in this rule.

We also reiterate that our intention is to align the reporting requirement at § 442.43 with similar reporting requirements finalized in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**, which focuses on the percent of Medicaid payments for certain HCBS going to compensation for the direct care workforce. The purpose of these aligned requirements is to provide a consistent picture of the percent of Medicaid payments going to compensation for the direct care workforce for Medicaid-covered LTSS across settings. Not only would adding reporting on Medicare payments be out of scope for this reporting requirement, we believe that doing so would obscure data on the allocation of Medicaid payments. We thank commenters for their feedback and will consider a reporting requirement for Medicare payments for future rulemaking.

*Comment:* A few commenters agreed that beneficiary contributions, such as co-pays (to the extent they exist) should also be included in the revenue side of the calculation. A few commenters noted that because beneficiary contributions can fluctuate, they can have an impact on the resources available for compensation to staff and thus should be included in the reporting.

One commenter asked for clarification on which beneficiary contributions should be included. The commenter noted that in the proposed rule we mentioned deductibles and coinsurance but did not mention resident contributions to the cost of their care as a result of Medicaid rules for post-eligibility treatment of income (PETI). The commenter expressed concern that

we had not listed all types of beneficiary contributions in the regulatory text.

*Response:* We thank commenters for their support. We clarify that beneficiary contributions, including contributions to the cost of their care as a result of Medicaid rules for PETI, are part of Medicaid total payments for the purposes of this reporting requirement. We decline to specify beneficiary contributions in the regulatory text because we believe these are already understood to be part of total Medicaid payments. As noted in the proposed rule at 88 FR 61387, § 447.15 defines payment-in-full as "the amounts paid by the agency plus any deductible, coinsurance or copayment required by the [State] 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 under managed care delivery systems that is spent on compensation for direct care workers and support staff.

*Comment:* Most commenters who responded to our comment solicitation on small provider exemptions did not support exempting small providers from the reporting requirement because a complete picture of Medicaid spending on compensation in all nursing facilities and ICFs/IID is critically needed. A few commenters agreed with the reasons we cited in the proposed rule, that excluding certain providers would create the potential for disincentivizing providers to accept Medicaid patients. A commenter noted that ICFs/IID in particular tend to be small, so excluding small providers could mean a significant number (if not all) of some States' ICF/IID providers might be exempted.

One commenter did support excluding certain providers, noting that providers with a low number of nursing beds or extremely high or extremely low Medicaid utilization will typically not have operating costs that reflect the average for the industry and as such may change the State reported averages. The commenter proposed that providers should be excluded from reporting information required by this rule if they have any of the following characteristics during the reporting period: (1) Medicaid utilization based on census of 30 percent or less; (2) Medicaid utilization based on census of 80 percent or more; or (3) 40 or fewer

Medicaid-certified beds. One commenter recommended excluding payments for out-of-State single-case agreements, due to the difficulties collecting data from out-of-State facilities.

*Response:* We thank commenters for their feedback regarding concerns related to offering exemptions from the reporting requirement. We agree that offering exemptions would create disincentives to serve Medicaid beneficiaries and would not provide a comprehensive picture of compensation for the direct care and support staff workforce. We also note that we are especially interested in the expenditures of facilities serving a high percentage of Medicaid beneficiaries and, thus, would not wish to exclude them from this reporting. We will not modify this reporting requirement to add exemptions for providers. We will provide technical assistance as needed to address payments for Medicaid beneficiaries in out-of-State facilities.

*Comment:* One commenter expressed concern about the impact of dually eligible individuals on cost calculations, as Medicaid does not bear the cost of therapy provision or prescription drugs for dually eligible nursing facility residents.

*Response:* As discussed in the proposed rule at 88 FR 61386, 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 will provide technical assistance on how to calculate costs for dually eligible residents whose nursing facility care is being covered by Medicaid, but some aspects of their care are paid for by Medicare.

After consideration of the comments received, we are finalizing the requirements at § 442.43(b)(1) and (2) as proposed.

We are also finalizing at new § 442.43(b)(3) an exemption of data from Indian Health Service (IHS) and Tribal health programs subject to 25 U.S.C. 1641. During our finalization of the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**, it came to our attention that requirements potentially affecting IHS or Tribal provider expenditures would conflict with 25 U.S.C. 1641, governing how IHS and Tribal health programs may use Medicare and Medicaid funds, and other applicable laws providing for Tribal self-governance and self-determination. Although we are not finalizing a requirement in this final rule to require that providers spend a

minimum percentage of their Medicaid payments for nursing facility or ICF/IID services on direct care worker and support staff compensation, we have left open the possibility that the data collected under § 442.43 could help inform a minimum performance proposal in future rulemaking. Given the conflict between such a minimum performance requirement and the statutory requirements at 25 U.S.C. 1641, we will be unable to use data from IHS and Tribal health programs to inform future policy making related to direct care worker and support staff compensation. We believe that requiring States to report on data from IHS and Tribal programs would create unnecessary burden and (given their current allocation requirements) might skew the other data States would collect and report to CMS. Further, we note that finalizing an exemption for IHS and Tribal programs at § 442.43(b)(3) aligns with an exemption in the compensation reporting requirement finalized at § 442.311(e)(2) in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register**.

#### F. Report Contents and Methodology

At § 442.43(c)(1), we proposed 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 solicited comment on our proposal that information be reported at the facility level, particularly on any concerns about potential burden on providers and States.

We proposed 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 stated in the proposed rule at 88 FR 61387 that 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. We requested 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 proposed 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. For reasons discussed in the proposed rule at 88 FR 61387 through 61388, we did not propose to codify a specific reporting methodology. In the proposed rule at 88 FR 61387, we stated that 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 solicited initial suggestions for an appropriate methodology for identifying the percentage of Medicaid payment that has gone to direct care worker and support staff compensation. We also solicited initial suggestions about whether separate methodologies would be appropriate for FFS base payments and supplemental payments and if so, suggestions for each. Commenters who supported adding a requirement to report median hourly wages were also asked to provide suggestions for a methodology for those calculations.

To support our goal of transparency, we considered adding a provision requiring that States make publicly available information about the underlying FFS payment rates themselves for nursing facility and ICF/IID services. For the reasons discussed in 88 FR 61388, we considered 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). We also requested comment on whether the reported average should be the average of only the per diem FFS base payment rates or the average of the per diem FFS base payment rates plus FFS supplemental payments.

Finally, as discussed in 88 FR 61388, in consideration of potential future rulemaking, we requested 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 requested 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 requested 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 was recommended, we requested 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 requested that commenters provide data or evidence to support such recommendations, which we will review as part of our consideration of policy and rulemaking options.

We received comments on our proposal. The following is a summary of these comments and our responses.

*Comment:* A few commenters expressed support for the requirement that States collect data at the facility level. A commenter noted specific support for including both privately- and publicly owned facilities.

A few commenters noted that facility-level reporting may be burdensome. One of these commenters asked for clarification as to whether the reporting will be by provider or by facility; the commenter noted that some providers operate multiple individual facilities and that requiring reporting at the facility level rather than the provider level will increase burden.

*Response:* As stated in our proposed requirement at § 442.43(c), the reporting gathered by the State should be at the facility level (but reported to CMS, for each nursing facility, as a single aggregated percentage for direct care worker compensation and, separately, a single aggregated percentage for support staff compensation and, for each ICF/IID, a single aggregated percentage for direct care worker compensation and, separately, a single aggregated percentage support staff compensation). We will provide technical assistance to

States on how to collect data from providers that operate multiple facilities to minimize administrative burden.

*Comment:* Many commenters supported disaggregating the reporting requirements by job duty or title, rather than reporting a percentage for direct care workers and a percentage for support staff. Several commenters also supported requiring reporting on median hourly wages (again, disaggregated by job duty). These commenters noted that wages for different types of direct care workers and support staff are wide ranging, and commenters were concerned that posting broad categorical percentages or median hourly wages for a range of job classifications would not provide transparency regarding how the facility is staffed and how each type of worker is compensated.

Other commenters did not support reporting on median hourly wages. A commenter, representing a number of State Medicaid agencies, stated that while some Medicaid agencies agreed that this data would help evaluate the impact of rate increases on staff wages, others were strongly opposed to additional reporting due to the increased administrative burden on States and providers. A commenter noted that the cost reports in the commenter's State do not currently include median hourly wages and that having to obtain that information from facilities would significantly increase burden.

A few commenters believed that if median hourly wage was reported, it should be reported for total compensation. One of these commenters observed that facilities might have to make changes to their facility's human resources or accounting software to accommodate further disaggregation of wage reporting. The commenter also noted that the wide variety of salary or wage types and pay systems would make data disaggregated beyond total compensation difficult to compare among States and across providers.

A few commenters suggested that this reporting be disaggregated by the subcategories of compensation listed in the definition of compensation at § 442.43(a)(1). A few commenters suggested that the subcategories should be further disaggregated, such as requiring reporting separately on overtime payments, the cost of paid time off, and the cost of health benefits.

A few commenters suggested we require disaggregation beyond compensation subcategory or job duty. A commenter suggested we require disaggregating median wage by part- and full-time status, as well as by

contracted and employee status, which the commenter believed would allow policymakers to better understand the relationships between Medicaid payment, provider employment practices, and quality of care. A commenter, making a similar suggestion to require separate reporting of contracted staff, also suggested we require that facilities report whether they have an ownership interest in the third-party entity providing the contracted services. A few commenters suggested we require separate reporting on wages paid to new staff, to ensure facilities were appropriately investing in increasing staffing levels. A commenter suggested reporting on whether a facility offers health and retirement benefits and the percent of workers enrolling in those benefits. A few commenters also recommended we encourage States to collect data that would demonstrate racial, gender, and career advancement disparities.

A few commenters suggested that reporting be disaggregated by rate component. A commenter explained that due to the large variations between the Medicaid reimbursement systems used in the States and territories, reporting by rate component would allow for a variety of percentage of payment calculations by individual rate component and in total.

*Response:* We are finalizing the Federal reporting requirement as proposed (to require aggregated reporting of direct care worker compensation and support staff compensation) and without requiring reporting on median hourly wages.

In previous comment summaries and responses, we discussed concerns about variations in job titles and duties and are concerned that requiring payment broken down by job title may make national comparisons difficult, and significantly increase the reporting burden. For similar reasons, we decline at this time to require reporting on median hourly wage. As noted by commenters, there are variations among State and local wage laws and cost of living that would make meaningful comparisons of median hourly wages difficult at a national level. We believe it is important to first establish competency with collecting and reporting broad baseline data before requiring more granular reporting, although we recognize there could be value to collecting more granular data, including on median wages, in the future.

Additionally, upon consideration of the comments, we have identified no compelling reason to implement a Federal requirement for disaggregating

the data by compensation category. We believe that employee benefits, in addition to wages, are also integral to the compensation of direct care workers and support staff. The third component of compensation—employers' share of payroll taxes—is a fixed percentage of the employee's wages set by law.

We thank commenters for their thoughtful feedback and suggestions for additional reporting components or metrics. We note that States may, at their discretion, require additional disaggregated data that they feel would be helpful in tracking local trends in workforce compensation and providing oversight and transparency.

*Comment:* Many commenters recommended that nursing homes should be required to detail other expenses, including any payments to related parties. These commenters believed that this would support greater financial transparency. One commenter recommended that both Medicare and Medicaid cost reports be made publicly available to disclose the total amount of spending on nursing, ancillary, and support services compared with spending on administration, property, profits, related party transactions, and disallowances.

One commenter recommended that additional data be collected on other outcome measures, including staffing levels for direct care workers and workers who provide indirect care (such as housekeeping or food services); the number of short- and long-stay residents; payer distribution of residents; quality measures constructed from the Minimum Data Set; safety measures constructed from health inspection data collected from nursing homes during on-site inspection surveys; medical outcomes from Medicare data, including hospital admissions, emergency department visits, mortality, hospital readmissions, and successful community discharge (short stay); and results from surveys of residents, family, and staff.

*Response:* We thank commenters for their suggestions but note that recommendations regarding reporting on expenditures other than compensation are out of scope for this rule, as are requests that we create and finalize requirements regarding cost reports. As stated in prior responses, the purpose of this requirement is not the granular tracking of all facility expenditures. As discussed at length in the proposed rule at 88 FR 61831 through 61833, understaffing in facilities is well-documented and chronic and poses a risk to the quality of care, and thus we have made addressing compensation for

institutional direct care workers and support staff a particular focus of this requirement. We recognize the role of related-party and other transactions in affecting the overall costs and profits of nursing facilities, and in turn the amount of funding available for direct care and administrative staffing; we will examine this issue and its impacts on quality in the future.

We also note that Nursing Home Compare contains a great deal of information regarding quality measures for nursing facilities.

*Comment:* Although they did not necessarily provide recommendations for a methodology, some commenters expressed concerns about how the required information will be calculated. These concerns include:

- For facilities that accept payments from multiple payers, identifying the amount of compensation for services provided to residents with stays covered by Medicaid;
- Accounting for variations in beneficiary acuity, which can impact both the amount of Medicaid payments and the facility resources allocated to the beneficiaries;
- Accounting for third party contracts in which (1) the contract price includes wages, benefits, and administrative costs, or (2) all-inclusive contracts (in which a facility pays a monthly rate for labor, supplies, and other items);
- Calculating the percent of Medicaid payments going to compensation if the Medicaid payment is less than the facility's standard rate; and
- Determining a reporting period (such as provider fiscal year, State fiscal year, or calendar year) that promotes consistency without creating administrative burden or confusion for providers.

A few commenters made specific suggestions regarding methodology and the reporting period. A commenter recommended the percentage be calculated by determining (a) a per diem salary cost amount (compensation costs divided by total patient days) and (b) a per diem revenue amount (Medicaid payments divided by Medicaid days), and dividing amount (a) by amount (b). The commenter cautioned, however, that this method will not provide information about whether revenues are being diverted away from patient care.

A commenter noted that a potential challenge could arise when accounting for payment adjustments that occur in one year that are paid in a different year, which could either under-report or over-report the payments to providers. To address this, the commenter suggested that States be required to report payments based on actual dates of

service, not the dates payments are made to providers.

A commenter recommended that the reporting period should be the facility's fiscal year or cost report year, but that changes in the reporting period should be allowed if the facility changes ownership. A commenter suggested we allow States to determine the reporting period.

A few commenters suggested we develop a reporting methodology based on a review of current nursing facility and ICF/IID cost reports or other State-level reporting practices.

*Response:* We thank commenters for their feedback, which we will take into consideration when developing the reporting methodology and reporting template (including reporting period), that we will be making available for public comment through the Paperwork Reduction Act notice and comment process. This will give the public the opportunity to provide specific feedback and help us align the methodology and reporting process with existing State practices to the greatest extent possible.

We received public comment on our solicitation regarding whether we should require State reporting on per diem Medicaid FFS payment rates for nursing facilities and ICFs/IID. A few commenters wrote in support of adding this requirement to the reporting requirement at § 442.43(c). However, we have finalized a requirement at § 447.203(b)(1) in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register** requiring State agencies to publish all Medicaid FFS fee schedule payment rates on a website that is accessible to the general public. We are not finalizing a reporting requirement at § 442.43(c) that would largely duplicate the reporting requirement at § 447.203(b)(1).

We received responses to our request for comment on whether, as part of future rulemaking, 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 received comments both in support of and in opposition to the idea of requiring a minimum threshold. We did not receive comments providing data supporting a specific minimum threshold. We thank commenters for their feedback and will take these comments into consideration in pursuing any future rulemaking on this issue.

After consideration of the comments received, we are finalizing § 442.43(c)(1) and (2) as proposed.

### G. Website Posting

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 proposed new requirements to promote public transparency related to the administration of Medicaid-covered institutional services. For the reasons discussed in 88 FR 613888 and 61389 we proposed at § 442.43(d) to require States to operate a website that meets the availability and accessibility requirements at § 435.905(b) and that provides the results of the newly proposed reporting requirements in § 442.43(b). We requested 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 noted 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.

At § 442.43(d)(1), we proposed 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(s) that is contracted to cover nursing facility or ICF/IID services. We explained our intent 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 a managed care delivery system 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 requested 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 proposed to require that the website include clear



and easy to understand labels on documents and links. At § 442.43(d)(3), we proposed to require that States verify the accurate function of the website and the timeliness of the information and links at least quarterly. 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's 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 did not propose 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, cease linking to that managed care plan's website and begin posting the required reporting information on a State-maintained website. We requested 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 proposed 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. We also proposed to require that States 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 requested comment on whether these requirements would be sufficient to ensure the accessibility of the information for people receiving nursing facility or ICF/IID services and other interested parties.

We also proposed 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 ICFs/IID 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 envisioned using data from State reporting in future iterations of the CMS Medicaid and CHIP Scorecard.<sup>92</sup> In the proposed rule at 88 FR 61389, we noted 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 received public comment on these proposals. The following is a summary of these comments and our responses.

*Comment:* A few commenters stated that they supported requiring States to have only one website with all the data and information related to reporting requirements. A commenter noted that this makes accessing data much easier and more accurate than external links to managed care plans' websites. A commenter requested we also require that data be in a downloadable format that supports use of the data, to support analysis by the public, researchers, and other interested parties.

*Response:* We decline to make modifications to this requirement. We agree with commenters that having one website on which the public may access data is a good practice. However, we have finalized a requirement at § 441.313(a)(1) in the Ensuring Access to Medicaid Services final rule published elsewhere in this **Federal Register** that gives States flexibility to maintain either a single website or link to managed care plan websites. To provide parity for both HCBS and institutional Medicaid services, we are finalizing the substantive requirement at § 442.43(d) as proposed, allowing States to meet this requirement by linking to individual MCO or PIHP websites. (We note that we are finalizing § 442.43(d) with technical modifications to correct a grammatical error.)

Although we decline to add technical specifications for the data format to the regulatory text, we do expect that States (or managed care plans, as applicable)

will make this information available in a format that is accessible, downloadable, and otherwise usable for members of the public.

*Comment:* A commenter noted support for the requirement that language on the website be clear and easy to understand.

*Response:* We thank the commenter for their support. We are finalizing the requirement at § 442.43(d)(1) as proposed.

*Comment:* A few commenters supported quarterly review of the website. A commenter suggested we require that missing or inaccurate information be remedied within 2 weeks of the review. The commenter stated that delayed reviews can lead to the posting of inaccurate data, which hampers transparency initiatives. A commenter, noting the importance of transparency in reporting, stated that States should expect managed care plans to review their websites on a monthly basis at a minimum.

*Response:* We are finalizing the review requirement at § 442.43(d)(2) as proposed. We agree with commenters that quarterly review is an appropriate review frequency that balances oversight with administrative burden, given that the data itself are updated annually. We note that States or managed care plans have discretion to review the website more frequently as needed. We also decline to require a specific deadline by which outdated or erroneous data or broken links are to be updated, noting that issues might take different amounts of time to resolve. We expect that States will ensure that outdated or erroneous information, or broken links, will be remedied as promptly as possible. In addition, if a State becomes aware that posted information is outdated or erroneous and the issue cannot be addressed very rapidly, we expect that the State (or managed care plan) will publish a notice on the web page identifying the information concerned and stating that revised information is expected to be published in the future, giving the timeframe if available, so that the public will be appropriately cautioned not to rely on the outdated or erroneous information.

*Comment:* A few commenters stated that the accessibility standards outlined in the proposal appear sufficient to ensure access and availability of information, including to people with disabilities, people with limited English proficiency, and people who require the information in other languages. A few commenters also supported the requirement requiring prominent language that additional assistance is

<sup>92</sup> CMS's Medicaid and CHIP Scorecard. Accessed at <https://www.medicicaid.gov/state-overviews/scorecard/index.html>.

available at no cost, with clear instructions for requesting assistance or additional accommodations. A commenter suggested that the website include the contact information for a “designated individual within the State Medicaid agency responsible for nursing facility oversight who is available to address any accessibility concerns.” One commenter recommended we require the website include the State Medicaid agency contact information so that members of the public can contact someone with questions about the data.

*Response:* We are finalizing the accessibility requirements at § 442.43(d) introductory text and (d)(3) as proposed. We decline to formalize any additional requirements in the regulatory text but agree that including relevant contact information on the website is important for ensuring the information is available and accessible to the public. We also note that having contact information on the website for a relevant contact at the State Medicaid agency would aid in the quarterly review finalized at § 442.43(d)(2) by allowing the public to notify the State of any errors or operational issues with the website. We encourage States to implement this practice, even though we are not formally requiring its adoption.

*Comment:* A commenter did not support requiring the public posting of facilities’ cost data. The commenter noted that this may be particularly problematic for ICFs/IID, which range in size and can be quite small. The commenter was concerned that publicizing facilities’ cost data could lead to inaccurate (presumably negative) conclusions being drawn about the facilities.

*Response:* The requirement is only for States to publish the percent of a facility’s Medicaid payments that are going to worker compensation, not more detailed cost data (such as the amount of Medicaid payments or the amount paid to workers). While States may, at their discretion, decide to publish more detailed information, we believe the Federal requirement strikes a balance between promoting transparency and allowing for the sharing of aggregated (rather than granular) data about facilities’ financial activities.

We did not receive comments on our proposal at § 442.43(e).

After consideration of the comments received, we are finalizing § 442.43(d) with minor technical modifications to change “MCO and PIHP websites” to “MCO’s and PIHP’s websites.” We are finalizing § 442.43 (e) as proposed.

#### *H. Applicability Date and Application to Managed Care*

For reasons discussed in 88 FR 61389 through 61390, we proposed, 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 systems, and contracts to support implementation of the proposals outlined in this section. We invited 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 proposed to apply the requirements at § 442.43 to both FFS and managed care delivery systems through adoption by reference in a new regulation in 42 CFR part 438, which generally governs Medicaid managed care programs. Specifically, we proposed 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 proposed 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 section 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 proposed 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

solicited feedback on the proposed application of the reporting requirement to managed care delivery systems, and the proposed timeframe for compliance. We also invited 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 received comments on these proposals. The following is a summary of these comments and our responses.

*Comment:* A few commenters suggested that we shorten the timeframe for compliance, especially given the importance of the data being collected and the urgency of the understaffing in facilities. A commenter stated that 4 years was unnecessarily long and recommended 2 years as a reasonable alternative. A few commenters recommended 3 years, stating that States and facilities should already have much of the required data available.

A few commenters recommended a longer timeframe than 4 years, such as 6 or 7 years. These commenters cited challenges such as limited State staff and financial resources to dedicate to completing this reporting requirement; obligations to comply with other new reporting obligations; a backlog of eligibility determinations following the end of the COVID–19 Public Health Emergency; support needed to help providers, especially smaller providers, update their systems to report the necessary data; and time and resources needed to update States’ systems to collect, process, and audit the required data.

One commenter supported the 4-year applicability date if the rule is finalized as proposed.

*Response:* We are finalizing the 4-year applicability date that we proposed at § 442.43(f). We believe that 4 years strikes an appropriate balance between obtaining these data as quickly as possible and acknowledging that some States and providers will need time to update systems. As noted in prior responses, we also intend to make the reporting methodology and reporting format available to the public through the Paperwork Reduction Act notice and comment process. We believe the 4-year delayed applicability date provides sufficient time for this process, as well as any subregulatory guidance or technical assistance needed to assist States to prepare for and be in compliance with the requirements.

We did not receive specific comments on the proposal to add a cross-reference at § 438.72(a) to apply the reporting requirements finalized at § 442.43 to

managed care plans and the associated applicability date for MCOs and PIHPs.

After consideration of the comments received, we are finalizing the substance of § 442.43(f) as proposed, but with minor modifications to correct erroneous uses of the word “effective.” We are retitling the requirement at § 442.43(f) *Applicability date* (rather than *Effective date*). We are also modifying the language at § 442.43(f) to specify that States must comply with the requirements in § 442.43 beginning 4 years from the effective date of this final rule, rather than stating that § 442.43 is effective 4 years after the effective date of the final rule.

Additionally, we are finalizing both §§ 442.43(f) and 438.72(a) with technical modifications (discussed in the next paragraph) regarding the applicability date for States providing nursing facility and ICF/IID services through managed care plans. The purpose of these modifications is to streamline § 438.72(a) and consolidate all applicability dates in § 442.43(f). We also believe these modifications better align the structure of §§ 438.72(a) and 442.43(f) with similar requirements finalized at § 438.72(b) and a number of applicability dates in the Ensuring Access to Medicaid Services Final Rule published elsewhere in this **Federal Register**.

As proposed, § 438.72(a) included a requirement that States that included nursing facility or ICF/IID services in their MCO and PIHP contracts must comply with § 442.43, as well as specifying that States must comply with § 442.43 by the first rating period for contracts with the MCO or PIHP beginning on or after 4 years after the effective date of the final rule. We are striking the applicability date language from § 438.72(a) and finalizing § 438.72(a) with modified language that simply specifies that the State must comply with requirements at § 442.43 for nursing facility and ICF/IID services. We are finalizing § 442.43(f) with a modification to add (with minor modifications) the language that had been originally proposed at § 438.72(a), specifying that in the case of the State that implements a managed care delivery system under the authority of section 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes nursing facility services or ICF/IID services, States must comply beginning the first rating period for contracts with the MCO or PIHP beginning on or after 4 years after the effective date of the final rule.

#### *I. Future Guidance and Interested Parties Advisory Group Comment Solicitation*

As noted in the proposed rule at 88 FR 61390, as a result of finalizing the proposals as discussed, we will 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 invited 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 requested comment on whether we should propose that States implement an interested parties’ advisory group in parallel with proposed requirements at § 447.203(b)(6) finalized in the Ensuring Access to Medicaid Services rule published elsewhere in this **Federal Register**, which requires 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 solicited comment from the public on whether we should consider developing requirements for States to establish a similar group to advise and consult on nursing facility and ICF/IID service rates.

We received a few comments from the public that supported this proposal. We thank commenters for their feedback and will take the comments into consideration should we pursue rulemaking in the future.

#### **IV. Provisions of the Final Regulations**

In this final rule, we are adopting the provisions of the September 6, 2023, proposed rule with the following modifications:

- In § 442.43(a)(1), we modified paragraph (a)(1)(ii) to specify that compensation includes benefits, such as health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement.
- In § 442.43(a)(2), we redesignated paragraphs (a)(2)(vi) through (x) as paragraphs (a)(2)(vii) through (xi), respectively, and added a new paragraph (a)(2)(vi) to include direct support professionals to the definition. Additionally, we are finalizing the newly redesignated paragraph (a)(2)(xi) with a modification to include nurses and other staff that providing that clinical supervision.

- In § 442.43(a)(3), we redesignated paragraph (a)(3)(vi) as paragraph (a)(3)(vii) and added a new paragraph (a)(3)(vi) to add security guards to the definition of support staff.

- We are finalizing a new definition of excluded costs at § 442.43(a)(4), which are costs reasonably associated with delivering Medicaid-covered nursing facility or ICF/IID services that are not included in the calculation of the percentage of Medicaid payments that is spent on compensation for direct care workers and support staff. Such costs are limited to: (1) costs of required trainings for direct care workers and support staff (such as costs for qualified trainers and training materials); (2) travel costs for direct care workers and support staff (such as mileage reimbursements and public transportation subsidies); and (3) costs of personal protective equipment for facility staff.

- In § 442.43(b), we removed “by delivery system and,” added language specifying that the Medicaid payments used in the required calculation do not include excluded costs, and added a cross-reference to § 442.43(b)(3). We are also finalizing technical modifications to improve clarity and correct grammatical errors.

- We are finalizing a new § 442.43(b)(3) to specify that States must exclude data from Indian Health Service and Tribal health program providers subject to 25 U.S.C. 1641.

- In § 442.43(d), we made minor technical modifications for grammar and readability, including changing “MCO and PIHP websites” to “MCO’s and PIHP’s websites.”

- In § 442.43(f), we retitled the requirement *Applicability date* and made minor modifications to the language to specify that States must comply with § 442.43 beginning 4 years after the effective date of this final rule. We also added to § 442.43(f) language (with minor modifications) that had been proposed in § 438.72(a) specifying that in the case of the State that implements a managed care delivery system under the authority of section 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes nursing facility services or ICF/IID services, States must comply beginning the first rating period for contracts with the MCO or PIHP beginning on or after 4 years after the effective date of the final rule.

- In § 438.72(a), we struck the language specifying an applicability date; the substance of this language was added to § 442.43(f). We streamlined the language at § 43.72(a) to specify that States must comply with requirements

at § 442.43 for nursing facility and ICF/IID services.

- Throughout chapter 42 of the CFR we have updated references to “§ 483.70(e)” to replace them with “§ 483.71”, as appropriate to reflect the new designation for the facility assessment requirements.

- In § 483.35, we redesignated the updates to existing paragraph (a)(1) as a new paragraph (b) entitled “Total nurse staffing (licensed nurses and nurse aides)” and renumbered the existing paragraphs in § 483.35 accordingly.

- In § 483.35, we added a requirement at new paragraph (b)(1) for facilities to meet a minimum of 3.48 HPRD for total nurse staffing. Requirements at new paragraphs (b)(1)(i) and (ii) require facilities to also have a minimum of RN HPRD of 0.55 and NA HPRD of 2.45. In this redesignated paragraph we also are not including the proposed requirement for determinations of compliance with HPRD requirements to be made based on the most recent available quarter of PBJ system data submitted in accordance with § 483.70(p).

- In § 483.35, we revised newly redesignated paragraph (c)(1) to add that facilities may be exempted from 8 hours per day of the 24/7 RN onsite requirement if they meet the exemption criteria outlined in new paragraph (h).

- In § 483.35, we added a new paragraph (c)(2) to require that during any periods when the onsite RN requirements in paragraph (c)(1) are exempted under paragraph (h), facilities must have a registered nurse, nurse practitioner, physician assistant, or physician available to respond immediately to telephone calls from the facility.

- In § 483.35, we redesignated existing paragraphs (e) and (f) as paragraph (f) and (g), respectively. In newly redesignated paragraph (f), we revised the heading to read “Nursing facilities: Waiver of requirement to provide licensed nurses and a registered nurse on a 24-hour basis.” In newly redesignated paragraph (g), we revised the heading to read “SNFs: Waiver of the requirement to provide services of a registered nurse for at least 112 hours a week”.

- In § 483.35, we redesignated proposed new paragraph (g) as a new paragraph (h) and revised the heading to read “Hardship exemptions from the minimum hours per resident day and registered nurse onsite 24 hours per day, for 7 days a week”.

- In § 483.35, we revised new paragraph (h) to add that a facility may be exempted from both the minimum hours per resident day required in paragraph (b) and 8 hours per day of the 24/7 RN onsite requirement at paragraph (c)(1).

- In § 483.35, we revised new paragraph (h) to withdraw the 20 mile distance qualifier for an exemption from the minimum hours per resident day requirement. Qualifying location criteria to be eligible for an exemption is based on workforce unavailability only.

- In § 483.35, we revised new paragraph (h) to modify the transparency requirements that a facility must meet to receive an exemption from the minimum hours per resident day and 8 hours of the 24/7 RN onsite requirements. In addition to demonstrating a good faith effort to hire and identifying the annual amount of funds dedicated to hiring efforts, facilities must also post in the facility and provide notices to residents and the LTC ombudsman of their exemption status and inability to comply with the minimum staffing requirements, including the degree to which they do not meet the staffing requirements.

- In new § 483.71, we modified the proposal at paragraph (b) to clarify the required involvement of specific staff in the development of the facility assessment. LTC facility staff, including nursing home leadership (governing body, etc.) and direct care staff (RNs; LPN/LVNs; NAs; representatives of direct care staff, if applicable; and other specialties) must be offered the opportunity to actively participate. Facilities must also solicit and consider input from residents, and resident representatives.

- We revised the implementation timeframe to reflect the following:

++ Non-rural Facilities

++ Phase 1 (90 days after publication)—  
Facility Assessment Updates  
(§ 483.71)

++ Phase 2 (2 years after publication)—  
Minimum 3.48 HPRD for total nurse  
staffing and 24/7 RN Requirements  
(§ 483.35(b)(1) and (c)(1))

++ Phase 3 (3 years after publication)—  
Minimum .55 RN and 2.45 NA HPRD  
Requirements (§ 483.35(b)(1)(i) and  
(ii))

++ Rural Facilities (as defined by OMB)  
—Phase 1 (90 days after publication)—  
Facility Assessment Updates  
(§ 483.71)

—Phase 2 (3 years after publication)—  
Minimum of 3.48 HPRD for total  
nurse staffing HPRD and 24/7 RN  
Requirements (§ 483.35(b)(1) and  
(c)(1))

—Phase 3 (5 years after publication)—  
Minimum .55 RN and 2.45 NA HPRD  
Requirements (§ 483.35(b)(1)(i) and  
(ii))

## V. 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](https://www.bls.gov/oes/current/oes_nat.htm). We have calculated the estimated hourly rates in this 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 5 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)<sup>93</sup> was used.

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**Table 5: 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	Dietitians 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 solicited public comments on each of these issues for the following sections of this document that contain information collection requirements (ICRs). Based upon our analysis of

comments received, we are revising our burden estimates and adding a burden estimate for LTC facilities (LTCFs) to solicit and consider any input received by residents, resident representatives, and family members. These revisions and the addition are detailed below:

*A. ICRs Regarding § 483.35 Nursing Services*

At § 483.35(a), we proposed that each LTC facility would have to provide 0.55 HPRD for RNs and 2.45 HPRD for NAs.

In the proposed rule, we analyzed the COI requirement as indicated below.

<sup>93</sup> [https://www.bls.gov/oes/current/naics4\\_623100.htm](https://www.bls.gov/oes/current/naics4_623100.htm).

These proposed requirements would require each LTC facility to review and modify, as necessary, its policies and procedures regarding nurse staffing. 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 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 estimated that these activities would require 2 burden hours for an administrator at a cost of \$200 (\$100 × 2 hours), 3 hours for the DON at a cost of \$300 (\$100 × 3 hours), and 1 hour for the administrative assistant at a cost of \$41 (\$41 × 1 hour). 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) hours at a cost of \$7,946,208 (\$541 × 14,688 LTCFs).

*Comment:* Numerous commenters generally contended the proposed requirements were too burdensome and expensive. One provider organization stated that the estimate for the ICR burden that included two hours for an administrator, three hours for the DON, and one hour for an administrative assistant were grossly underestimated. The commenter asserted that LTC facilities would be required to review and modify nurse staffing policies and procedures to become compliant with the requirements, develop and modify contracts with staffing agencies, engage in budget modification and staffing model reevaluations based on the staff available to meet the new requirements, and determine appropriate resident placement efforts when the facility cannot be compliant with the requirements. The commenter also noted that there were likely other activities that would be required as well.

*Response:* We agree with the commenter that the burden estimated in the proposed rule for proposed § 483.35(a) was understated. We note that as discussed in section II.B.3. of this rule, we are finalizing at § 483.35(b) to require LTC facilities to provide a minimum total nurse staffing requirement of 3.48 HPRD (paragraph

(b)(1) introductory text), which includes 0.55 HPRD of RNs (paragraph (b)(1)(i)) and 2.45 HPRD of NAs (paragraph (b)(1)(ii)).

We are revising and increasing the burden estimate particularly to account for additional activities addressed by the commenters, including the review and modification of contracts, staffing models, and contingency planning to address when staffing or other resource issues arise. Thus, we are revising our burden estimate to allow for 8 hours at a cost of \$800 (\$100 × 8) for the administrator, 7 hours at a cost of \$700 (\$100 × 7 hours) for the DON, and 4 hours at a cost of \$164 (\$41 × 4 hours) for the administrative assistant. Hence, the total estimated burden for each LTC facility would be 19 hours at cost of \$1,664. For all 14,688 LTC facilities, the total estimated burden would be 279,072 hours (19 hours × 14,688) at a cost of \$24,440,832 (\$1,664 × 14,688).

#### *B. ICRs Regarding § 483.71 Facility Assessment*

At § 483.71 Facility assessment, we proposed to relocate the existing requirements at § 483.70(e) Facility assessment to the new § 483.71. We also proposed 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 proposed 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 proposed to add "using evidence-based, data-driven methods" (such as the MDS resident assessments or data from QAPI activities) and "behavioral health issues" so that the requirement would then read, "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 proposed to add "and skill sets" so the requirement would read, "The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population." 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 those changes.

We proposed 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 proposed to add "behavioral health" so that the requirement would read, "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 did not analyze any new or additional burden related to this change.

We proposed 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 included, but were not limited to, nursing home leadership, management, direct care staff and representatives and other service workers. 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 did not analyze any new or additional burden related to this change.

We proposed 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.

LTC facilities are either already using their facility assessments for these activities or will be based upon the other requirements in the 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, 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 and input from the various types of direct care staff in their facilities and representatives of these workers. We note that the time spent by these staff to participate in the facility assessment process should not be substituted 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 estimated 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 saved appropriately in the facility's records. We estimated that developing a recruitment and retention plan would require 6 hours for an administrator at a cost of \$600 (\$100 × 6 hours); 6 hours for the DON at a cost of \$600 (\$100 × 6 hours); 4 hours for a RN at a cost of \$296 (\$74 × 4 hours); 2 hours for a LPN/LVN at a cost of \$112 (\$56 × 2 hours); 2 hours for a nursing assistant at a cost of \$68 (\$34 × 2); and,

2 hours for an administrative assistant \$82 (\$41 × 2 hours). 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 LTCFs × 22 hours) at an estimated cost of \$25,821,504 (\$1,758 × 14,688 LTCFs).

*Comment:* Numerous commenters generally contended the proposed requirements regarding the facility assessment were too burdensome and expensive. One provider organization stated that the estimate of 22 staff hours for the facility assessment requirement grossly underestimated the burden to a LTC facility. One provider organization stated that complying with this requirement would require multiple staff members a significant amount of time to comply. Also, compliance would require an ongoing effort by multiple staff members. The commenter acknowledged that estimating the burden is complicated since it depends upon the number of revisions and is influenced by the changes in the resident population and staff in each facility.

*Response:* We agree with the commenter that there are more activities related to complying with the facility assessment requirement than were considered in the proposed rule. As discussed in detail in section II.B.6. of this rule, we are finalizing as proposed all of the proposed changes regarding the facility assessment, except for § 483.71(b) that has been revised to require LTC facilities to require the active participation of the nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator and the director of nursing; and direct care staff, including but not limited to, RNs, LPNs/LVNs, and NAs, and representatives of the direct care staff, if applicable. The LTC facility must also solicit and consider input received from residents, resident representatives, and family members.

Based upon our review and analysis of comments related to this estimated burden and our substantive revisions in this final rule, we have revised the estimated burden for the facility assessment requirement as detailed below.

In the proposed rule, for the development of this staffing plan the estimated burden was 22 hours at a cost of \$1,758. Based upon the comments received and further analysis, we now estimate that developing a recruitment and retention plan would require 10 hours for an administrator at a cost of

\$1000 (\$100 × 10 hours); 10 hours for the DON at a cost of \$1000 (\$100 × 10 hours); 8 hours for a RN at a cost of \$592 (\$74 × 8 hours); 4 hours for a LPN/LVN at a cost of \$224 (\$56 × 4 hours); 5 hours for a nursing assistant at a cost of \$170 (\$34 × 5 hours); and, 3 hours for an administrative assistant \$123 (\$41 × 3 hours). Thus, the burden for each LTC facility is 407 (10 + 10 + 8 + 4 + 5 + 3 = 40) hours at an estimated cost of \$ 3,109 (\$ 1000 + \$1000 + \$592 + \$224 + \$170 + 123). For all 14,688 LTC facilities the burden would be 587,520 hours (14,688 LTCFs × 40) at an estimated cost of \$45,664,992 (\$3,109 × 14,688 LTCFs).

In addition, this rule finalizes revisions to the facility assessment that would also require additional burden. For § 483.71(b), we proposed that LTC facilities would be required to include 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. We did not assess a burden for this proposal because it was a clarification and not a new requirement. However, as finalized by this rule, § 483.71(b) now requires that the LTC facility ensure the active involvement of nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator and the director of nursing; and, direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs; and, representatives of direct care staff, if applicable. The LTC facility must also solicit and consider input from residents, resident representatives, and family members. We believe that many of the specifically named staff positions are already included by most LTC facilities in their facility assessment development, review, and updating process. We are also not estimating a burden for the active participation of representatives of direct care staff, if applicable, because assisting those they represent already falls within their responsibilities. If any of the direct care staff have representatives, the LTC facility should be aware of those individuals. However, soliciting and considering any input received by residents, resident representatives, family members is a new requirement. We are not estimating a burden for reviewing the input since this would be part of the facility assessment process. Thus, a burden estimate is being assessed for the activities required to comply with that requirement. These revisions are detailed below.

For a LTC facility to solicit input from residents, resident representatives, and family members would require the LTC facility to identify all of these individuals, make them aware of the facility assessment process, and then solicit their input. LTC facilities would differ in how they communicate to the named individuals. Although LTC facilities are not required to establish resident or family groups, residents do have the right to organize and participate in resident groups (§ 483.10(f)(5)). If residents do form resident or family groups, the LTC facility must provide the group(s) with private space for them to meet and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. Based upon our experience, most LTC facilities have

established resident or family groups. LTC facilities could easily use these established communications pathways, as well as posting notices and sending emails to solicit input for the facility assessment from the named individuals. To comply with the requirement to solicit the input of these individuals identified in the facility assessment requirement, we estimate this would require an administrator 1 hour at \$100 per hour ( $\$100 \times 1 \text{ hour} = \$100$ ) to draft the text of the communication and then an administrative assistant 2 hours at \$41 per hour ( $\$41 \times 2 \text{ hours} = \$82$ ) to forward the communication to the required individuals. The text of the communication should include a brief description of the facility assessment process, the opportunity to submit input, how that input can be submitted, and the deadline to submit the input.

This would likely include posting of a notice in the LTC facility and forwarding the communication to the facility’s resident or family group(s). The consideration of this input would then be part of the facility assessment review and updating process.

Hence, the burden for each LTC facility would be 3 hours ( $1 + 2 = 3$ ) at an estimate cost of \$182 ( $\$100 + \$82 = \$182$ ). For all 14,688 LTC facilities, the total estimated burden would be 44,064 hours ( $14,688 \text{ LTCFs} \times 3 \text{ hours} = 44,064$ ) at a cost of \$2,673,216 ( $\$182 \times 14,688 \text{ LTCFs} = 2,673,216$ ).

The total estimated burden for the ICRs in part 483 is 910,656 ( $279,072 + 587,520 + 44,064$ ) hours at a cost of \$72,779,040 ( $\$24,440,832 + \$45,664,992 + 2,673,216$ ).

**TABLE 6: Total Burden for Part 483 ICRs**

LTC Requirements Section	Burden Hours Per LTCF	Cost Estimate Per LTCF	Burden Hours For all LTCFs	Cost Estimate For all LTCFs
§ 483.35 Policies and Procedures Nursing Services	19	\$1,664	279,072	\$24,440,832
§ 483.71 Facility assessment – Recruitment and Retention Plan	40	\$3,109	587,520	\$45,664,992
§ 483.71 Soliciting input	3	\$182	44,064	\$2,673,216
Totals	62	\$4,955	910,656	\$72,779,040

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 ([https://www.bls.gov/oes/current/oes\\_nat.htm](https://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 finalized 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 smaller given that some States contributions will be less than 50 percent. We requested 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. We did not receive specific comments on these burden estimates.

**3. Information Collection Requirements (ICRs)**

The following finalized changes will be submitted to OMB for their approval when our survey instrument has been developed; we are using feedback received during public comment on the 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 estimating the impact of this finalized rule. 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 information collection request. Note that we intend that the following finalized 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 final rule, under our Medicaid authority at sections 1902(a)(6) and 1902(a)(30)(A) of the Act with respect to FFS delivery systems, and sections 1902(a)(4) and 1932(c) of the Act with respect to managed care delivery systems, we proposed and are finalizing 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 ICFs/IID that are spent on compensation for direct care workers and support staff. (Our definitions of who is included in direct care workers and support staff, finalized at § 442.43(a)(2) and (3), respectively, are discussed in the preamble in section III. of this rule.) The intent of this requirement is for States to report separately, at the facility 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 proposed and are finalizing a cross-reference to the requirements in § 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 requirements at

§ 442.43(b) apply to both FFS and managed care delivery systems.

We considered, but are not finalizing, additional requirements that States 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. We considered, but are not finalizing, 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. We note that our cost estimates in the proposed rule included estimated costs for both of these additional reporting requirements and are no longer reflected in this ICR. We also note that we are finalizing an additional requirement (discussed in section III. of this final rule) that will allow providers to exclude certain costs (such as certain costs related to training, travel, and PPE) from their Medicaid payments when calculating the percent of Medicaid payments spent on compensation to direct care workers and support staff. We anticipate that this may lead to a slight increase in the State's burden to develop guidance for providers on how to apply these excluded costs in facility settings and have adjusted the ICR accordingly.

#### (1) State Institutional Payment Transparency Reporting Requirements and Burden

The burden associated with the reporting requirements finalized in this rule 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 are included in these calculations as well.<sup>94</sup> While we included these territories in our cost estimates, we continue to refer to the affected entities collectively as "States". We estimated both a one-time and ongoing burden to States to implement these requirements at the State level.

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

Under finalized § 442.43(b) and (c), we anticipate as a one-time burden 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, including guidance on excluded costs (one-time); (3) build, design, and operationalize an electronic system for data collection and aggregation (one-time); and (4) 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 requiring that States update their Medicaid State plans as part of this reporting requirement, and thus we did not estimate 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; 40 hours at \$100.64/hr. for a management analyst to update any related provider manuals and other policy guidance; 40 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; 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 a managed care delivery system.<sup>95</sup> 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 plan (that is, MCO and/or PIHP) 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 6,926 hours [(164 hours × 54 States) + (10 × 24 States)]. We estimate a cost of \$811,792 (54 States × [(40 hr. × \$111.18) + (40 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. × \$111.18]). The total cost is estimated at \$838,475 (\$811,792 + \$26,683). Taking into account the Federal contribution to Medicaid administration, the estimated State share of the cost would be \$419,237 (\$838,475 × 0.50).

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<sup>94</sup> 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.

<sup>95</sup> Data taken from Centers for Medicare & Medicaid Services, "Managed Long Term Services and Supports (MLTSS) Enrollees," available at <https://data.medicare.gov/dataset/5394bcab-c748-5e4b-af07-b5bf77ed3aa3>.

**Table 8: Summary of One-Time Burden for States for the Medicaid Institutional Payment Transparency Reporting Requirements at § 442.43(b)**

Requirement	No. 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	40	2,160	100.64	217,382	108,691
Build, design, and operationalize an electronic system for data collection, aggregate, and stratify reporting	54	54	Once	40	2,160	98.84	213,494	106,747
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	348	Once	164	6,936	Varies	838,475	419,237

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

Under finalized § 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 review and make any needed updates to guidance for nursing facility and ICF/IID services; 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 hours × 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	No. 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
Review and make any needed updates to nursing facility and ICF/IID provider guidance and manuals	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	54	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 final 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 finalized at § 442.43(b).

To estimate the number of nursing facility and ICF/IID providers that are being impacted by this rule, we used data from the CMS Quality Certification

and Oversight Reports (QCOR) system ([qcor.cms.gov](http://qcor.cms.gov)) to identify the total number of Medicaid-certified nursing facilities and ICFs/IID 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 ICFs/IID. In total, we estimate

19,907 Medicaid-certified nursing facilities and ICFs/IID are impacted by this finalized 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 finalized § 442.43(b), we anticipate that nursing facilities and ICFs/IID 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).

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 hours) 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 ICFs/IID for the Medicaid Institutional Payment Transparency Reporting Requirements at § 442.43(b)**

Requirement	No. 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 ICFs/IID will 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 hours) 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 ICFs/IID for the Medicaid Institutional Payment Transparency Reporting Requirements at § 442.43(b)**

Requirement	No. 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 are finalizing the requirement for States to operate a website that meets the availability and accessibility requirements at 42 CFR 435.905(b) and that provides the results of the finalized reporting requirements in § 442.43(b). We also are finalizing 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 previously, we anticipate that this provision will 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 requiring that States update their Medicaid State plans as part of this reporting requirement and are not estimating a burden associated with State plan amendments.

**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 hours) 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	No. 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 hours × 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 \$147,764 (\$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	No. 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

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**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	348	Varies	6,936	Varies	838,475	419,237	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	147,764	0
<b>TOTAL</b>	Varies	121,140	Varies	649,306	Varies	55,943,524	735,403	0



## 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 1.2 million Americans are residents in LTC facilities each day with Medicare and Medicaid serving as the payor for most residents.<sup>96</sup> As we discussed in detail in sections II. and III, 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.<sup>97 98 99</sup> Research also suggests that there is a relationship between inadequate staffing and nursing staff burnout, which can lead to high employee turnover.<sup>100</sup> 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 the Medicare and Medicaid programs, leading to higher spending due to more hospitalizations and unplanned Emergency Department visits.<sup>101 102 103</sup> The available evidence suggests that various types of requirements for LTC facility staff could increase the quality of care in LTC facilities. We also recognize, 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 are finalizing a 24/7 on-site RN requirement, minimum RN and NA HPRD requirements, and a total nurse staffing requirement or 3.48 HPRD, all of which aim to increase resident safety and quality of care while preserving resident access to care.

Specifically, we are requiring that LTC facilities provide RN coverage onsite 24 hours per day, 7 days a week (24/7 RN). In addition, we are requiring that they provide a minimum of 0.55 RN and 2.45 NA HPRD, and 3.48 total nurse staff HPRD. While the 0.55 RN HPRD, 2.45 NA HPRD, and 3.48 total nurse staff 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, 2.45 NA, and 3.48 total nurse staff HPRD standards, regardless of the individual facility's patient case-mix. Requiring 24/7 RN and a minimum number of 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. In many cases, facilities will need higher levels of staffing as a result.

#### 2. Medicaid Institutional Payment Transparency Reporting

In response to concerns about the chronic understaffing and low wages for the institutional workforce (discussed in detail in our proposed rule at 88 FR 61398 and 61399), we proposed new Federal reporting requirements that are intended to promote public transparency. States have a statutory obligation under section 1902(a)(30)(A) of the Act and the quality requirements in section 1932(c) of the Act for services furnished through managed care organizations (MCOs) (as well as for prepaid inpatient health plans (PIHPs), 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 also relied 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.

As discussed in section III. of this final rule, we are finalizing (with some modifications) our proposal to require that State Medicaid agencies report annually, at the facility level, 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.<sup>104</sup> We also proposed, and are finalizing, that States make this information available to the public by posting the information on a website. As discussed in the proposed rule at 88 FR 61399, we developed the requirement to focus on compensation because many direct care workers and support staff earn low wages and receive limited benefits.<sup>105</sup> Evidence suggests that there is a connection between wages and high rates of turnover among

<sup>96</sup> <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/cms-program-statistics-medicare-skilled-nursing-facility>.

<sup>97</sup> 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/>.

<sup>98</sup> 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/>.

<sup>99</sup> 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 U.S. 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.

<sup>100</sup> 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.

<sup>101</sup> 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/>.

<sup>102</sup> 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/>.

<sup>103</sup> 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 U.S. 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.

<sup>104</sup> 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.

<sup>105</sup> 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>.

some workers in the institutional workforce.<sup>106</sup> 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 are not currently being reported to CMS.

### B. Overall Impacts

We have examined the impacts of this final 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, Public Law 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 (Modernizing Regulatory Review) 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 the Office of Information and Regulatory Affairs (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 final rule, we have calculated the annual cost of the minimum staffing requirements in table 22 based on hours per resident day in CY 2021 dollars, assuming the implementation and enforcement of these hours per resident day requirements as being applied independent of a facility’s case-mix. We estimate that the aggregate impact of the staffing-related provisions in this rule, which includes a phased-in implementation of the requirement for 24 hours per day, 7 days per week RN onsite coverage, the 0.55 RN and 2.45 NA minimum HPRD requirements, and the 3.48 HPRD total nurse staff requirement will result in an estimated cost of approximately \$53 million in year 1, \$1.43 billion in year 2, \$4.38 billion in year 3, with costs increasing to \$5.76 billion by year 10. We estimate the total cost over 10 years will be \$43.0 billion with an average annual cost of \$4.30 billion.

There is uncertainty about the degree to which LTC facilities would bear the cost of meeting the minimum staffing and 24/7 RN requirements and how much of the costs would be passed onto payors (including Medicaid, Medicare, private insurers, and nursing facility residents). We expect LTC facilities would generally have 3 possible approaches to addressing the increased costs associated with the higher staffing levels: (1) reduce their margin or profit; (2) reduce other operational costs; and (3) increase prices charged to payors. LTC facilities may use some combination of these approaches, and those approaches could vary by facility and over time. These decisions could depend on a number of factors, including: the current margin levels of a facility; the cost increase due to the staffing requirements relative to current costs and revenues; the current level of operational costs; and the ability to negotiate prices with payors.

With regards to payors, we have facility level data on the percentage of resident days paid for by Medicaid, Medicare, and other payors for the

estimates in this RIA. We used these data to estimate the potential share of costs for each payor by weighting each facility’s increased costs by the percentage of resident days paid for by each payor type. As we show in table 23, the potential Medicaid share of costs excluding collection of information costs is 67 percent—that is, if all of the costs of the staffing requirements were passed on to payors, Medicaid could be expected to pay about two-thirds of the total costs. Similarly, as we show in table 24, the potential Medicare share of costs is approximately 11 percent of the total costs, with other payors potentially bearing the other 22 percent of the total costs. As we note in our analysis below, however, our cost estimates assume that LTC facilities and not payors will bear the rule’s costs.

Additionally, we have estimated in table 21 the economic impact of the 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. Under this final rule the requirements become effective in 4 years. We estimate an initial implementation cost of \$9,355,472 for years 1 to 4 (resulting in total initial implementation costs of \$37,421,888) and ongoing annual costs of \$18,305,713 per year starting in year 5.

In response to the proposed rule (88 FR 61352–61429), we received approximately 46,520 total comments, of which more than 16,000 included comments related to the content of the regulatory impact analysis related to the minimum staffing standards. Commenters included numerous individuals who were LTC residents/families/caregivers/staff, industry, national advocates, national professional organizations, labor unions, and academic researchers. In this final rule, we provide a summary of the public comments received and our responses to them, including relevant changes in the RIA methodology and estimate.

*Comment:* Many commenters expressed concern about the cost estimates and the estimates of the number of employees that facilities would need to hire to meet the proposed requirements, as well as the assumptions underlying these estimates. Some commenters stated CMS overestimated the cost of implementing the requirements since it assumed that nursing homes will retain LPNs/LVNs when the commenters expect that nursing homes will actually lay off

<sup>106</sup> 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.

LPNs/LVNs and replace them with lower paid NAs to meet the 2.45 NA HPRD requirement, significantly reducing this requirement's cost. They also suggested that the cost of meeting the 24/7 RN and 0.55 RN HPRD requirements would be much lower than estimated since nursing homes would similarly lay off LPNs/LVNs and replace them with RNs, rather than maintaining LPN/LVNs at current level. These commenters noted that the rule's requirement would cost only a small portion of the industry's revenues and suggested that CMS should implement an even a higher minimum staffing standard of 4.2 HPRD, with one outside study showing a 4.2 HPRD requirement including 0.75 RN HPRD, 1.4 license nurse HPRD, and 2.8 NA HPRD, would cost \$7.25 billion annually.

Other commenters stated that CMS underestimated the costs for the requirements in the proposed rule and the number of nurse staff necessary to meet the requirements. Several commenters cited high growth in staff costs for the individual facilities in which they work or manage over the past few years, especially during the public health emergency (PHE). Commenters stated that Medicare and Medicaid reimbursement rates have not kept pace with rising costs. Other commenters suggested that CMS consider including the cost of using agency/contract staff in the impact analysis and consider not increasing staffing minimums but rather mandating the wages that staffing agencies can charge so that nursing homes are able to succeed financially. Other commenters stated that CMS used wage labor data from 2019 that is no longer current to what facilities are paying and that assuming a 2.31 percent increase in real wage rates was underestimating future wage increases.

Other commenters cited individual analyses they had done of staffing and cost data, which showed different costs than we estimated with estimates ranging from \$4 billion to \$7.1 billion annually. Many commenters cited an analysis of the proposed rule done by CliftonLarsonAllen (CLA), which estimated that the proposed 24/7 RN requirement, 0.55 RN HPRD requirement, and the 2.45 NA HPRD requirement would cost a total cost of \$6.8 billion annually, even with exclusion of increases in real wage rates and higher wage rates for contract employees. This analysis also estimated that more RNs and NAs would need to be hired than what our analysis estimated. A large number of commenters also cited an analysis done

by Leading Age, which estimated a total cost of \$7.1 billion annually.

One commenter indicated that they had been involved with creating the Leading Age cost estimate and, writing in a personal capacity, noted that a central reason for the difference in costs was due to growth in wage rates from 2021 to 2023 and that this \$7.1 billion cost estimate is based on daily rather than quarterly nurse staffing data from the Payroll Based Journal (PBJ). This commenter also stated that CMS cost estimates failed to include a provider-based adjustment to account for the use of contract staff and that our estimated wage growth of 2.31 percent was too low. They suggested using more recent Medicare cost data and other wage source data and highlighted the need for a SNF-specific wage index based on audited cost reports. Finally, they noted that the cost estimate excludes some nursing homes where cost or staffing data were unavailable, including nursing homes in Guam and Puerto Rico, leading to an underestimation of the actual cost. Other commenters stated that the CMS analysis assumed no costs for facilities prior to each requirement going into effect and ignored the potential impact of these costs on Medicare, Medicaid, and non-Medicare/Medicaid payors.

*Response:* We appreciate the commenters sharing their insights into the costs that their facilities have accrued to hire staff in recent years, as well as the comments highlighting how using differing data sources, such as contract nursing wage rates, and assumptions, such as using daily rather than quarterly nurse staffing data from the PBJ, influence the estimated cost and the number of employees facilities would need to hire.

We appreciate the commenters sharing their various hiring practices and information about their costs for hiring nurse staff in recent years. As we highlighted in the proposed rule through various breakdowns of the data by state, facility size, geographical location (rural vs. urban), and whether the facility is certified by Medicare, Medicaid, or dual certified, the cost for facilities to meet the 24/7 RN and HPRD requirements varies.

We also appreciate the commenters referring us to the CLA and Leading Age analyses showing an estimated \$6.8 billion and \$7.1 billion annual cost, respectively, when the rule is fully in effect and providing a copy of these analyses. In reviewing these alternative cost estimates, we have identified key differences between our estimation strategy and these estimation strategies that appear to have led to differing

estimates and we provide additional information regarding why we have decided to retain our estimation strategy and model assumptions.

CLA's \$6.8 billion cost estimate indicates that it calculates the rule's cost using the median, or the wage rate including salaries and allocated benefits for the single employee who earns middle wage rate, for each staff type from Medicare cost reports released as of July 2023 using form S-3, Part V, column 5. We would note, however, that column 5 contains the loaded mean, or average wage rate including allocated benefits for the employee type. For example, for NAs, it contains the average loaded salaries for all NAs that the facility employs. In light of this inconsistency, we are unsure how this outside analysis calculated median wage rate using Medicare cost reports. Calculating the median hourly wage rate for each nurse staff type requires obtaining wage data on every NA, LPN/LVN, and RN in every facility, or alternatively, having each of the more 14,000 nursing homes share the data for the RN, LPN/LVN, and NA in their facility who earns the middle wage among all RNs, LPNs/LVNs, and NAs they employ. We do not have these data and do not know of a source that provides it. As such, we continue to use the loaded mean hourly wage to calculate costs for the final rule.

In reviewing the \$6.8 billion estimate, the provided documentation indicates that it is based on wage rates only for employees. In contrast, our estimate, as well as the Leading Age estimate, calculates costs based on average hourly wage rates for employees and contractors. Calculating costs based only on employee wages requires an assumption that hours that contract employees are currently working would not count toward the minimum requirements and lead to facilities needing to hire more staff to meet the requirement. This assumption leads to a higher cost for meeting the requirements. We would note, however, that all hours worked by both employees and contract staff count toward the requirements we are finalizing. In addition, including costs for both employees and contract staff provides a more accurate picture of the average hourly wage that each facility is paying to their nurse staff. As a result, in this final rule, we are maintaining the inclusion of all nursing hours worked by employees and contract staff to calculate additional employees needed and continue to use overall average hourly rates to calculate the cost.

The CLA estimate indicates that the \$6.8 billion cost was calculated based

on a combination of 2021 and 2022 Medicare cost reports, without specifying the share of reports that come from each fiscal year. Our analyses and all costs are measured in FY 2021 US dollars and costs each year are provided in real 2021 US dollars rather than nominal dollars. Adjusting for general inflation, \$6.8 billion in 2022 Dollars is approximately \$6.3 billion in 2021 US dollars.<sup>107</sup> For Leading Age's \$7.1 billion annual estimate, the authors indicate that it is based on 2023 US dollars, which they calculate by increasing costs from the 2021 cost reports by 13 percent to account for inflation. In 2021 US dollars this would similarly be \$6.3 billion.

In reviewing the CLA's \$6.8 billion estimate, the authors indicated that using Q1 2023 PBJ data, nearly 80 percent of nursing homes would need to hire staff to meet the 24/7 RN requirement based on daily data. Our review of Nursing Home Care Compare data from March 2023, however, shows that for the facilities for which RN hours per day data are available, only 24.5 percent of facilities, or 3,578 facilities, would need to hire RNs using the following formula: Total RN Hours per Resident Day = Reported RN Staffing Hours per Resident Day × Average Number of Residents per Day. The same analysis of Nursing Home Care Compare data from January 2024 similarly shows that only 22.1 percent, or 3,202 facilities would need to hire RNs to meet this requirement. For Leading Age's \$7.1 billion cost estimate, one commenter, writing in a personal capacity, indicated that they were involved in calculating this estimate and that the higher cost came by analyzing daily, rather than quarterly, data from the PBJ. While there may be days within a particular quarter where a nursing home that meets the requirements overall based on quarterly data did not meet it on an individual day, we estimate that they would reallocate their existing staffing resources to ensure compliance with the rule on a continual basis and to reflect resident census changes. As such, we disagree with the estimate that nearly 80 percent of nursing homes would need to hire staff to meet the 24/7 RN requirement. Our analysis estimates that only 22.2 percent of nursing homes would need to hire staff to meet the 24/7 RN requirement. We also assume that they would reallocate staff hours during the week to meet the 0.55 RN, 2.45 NA,

and 3.48 total nurse staff HPRD requirements.

We appreciate the comment about adjusting the cost based on the share of contract staff that a facility uses and taking into consideration the need to use contract staff to meet the requirements. We also appreciate the comment about taking into account facilities for which there are no salary or staffing data. As we have noted above, all cost estimates calculate facility wage rates for each nurse type based on wages for both employee and contract staff in each nurse (RNs, LPNs/LVNs, and NAs) type. With regards to missing facilities, we note that our analysis includes data from all available facilities where there was staffing information available in the October 2021 Nursing Home Compare dataset. This included 14,688 facilities out of 15,270 facilities, or approximately 96.1 percent (14,688/15,270). We believe, therefore, that the cost estimate would remain similar even if these additional nursing homes, for which staffing data were unavailable, were included in the analysis. We are, however, adding additional language in the detailed economic analysis below to clarify that wages are based on costs for both contract staff as well as employees, as well as to clarify how we imputed any missing data.

We appreciate the commenters feedback on expected increase in wage rates for nurse staff. We note that all cost estimates are provided in 2021 US dollars and the growth in wage rates we use, are real wage rate growth. That is, the estimates take into account annual inflation and assume that wages are meaningfully increasing above inflation. Over 10 years, we are estimating a nearly 23 percent increase in real wage rates. We note that between 2001 and 2017, a 16-year period, real wage rates for nurses increased by only 9.92 percent.<sup>108</sup> Reviewing Bureau of Labor Statistics data for more recent years also suggests that our estimated increase is reasonable. Between 2019 and 2022, average hourly nominal wages for NAs increased from \$14.77 to \$17.41, or 17.8 percent, while average hourly nominal wages for RNs increased from \$37.24 to \$42.80, or 7.6 percent. Taking into account inflation, however, real wages increased by approximately 3 percent for NAs and declined by 0.37 percent for RNs. As such, we believe that our estimate of a 23 percent increase in real wage rates for nurse staff in 10 years

does not underestimate growth in wage rates and we maintained this wage rate increase as cited in the proposed rule. In addition, we continue to use cost data from 2021 Medicare cost reports since our analysis provides all costs in 2021 US dollars addressing concerns that more recent wage data would provide a higher cost estimate in 2021 US dollars.

We appreciate the opportunity to provide clarification regarding costs that facilities may incur to hire staff prior to each requirement's effective date since facilities will likely start hiring staff to meet the requirements before the effective date. In the proposed rule, as well as this final rule, the cost estimates for each requirement includes costs that facilities may incur in the year before each requirement going into effect as they hire employees in anticipation of the requirement. For example, in the proposed rule, we proposed that for facilities located in urban areas, the 24/7 RN requirement would go into effect 2 years after the date of publication. This means that these facilities would be required to meet the requirement starting 2 years, or 24 months, from the date of publication. In the cost analysis, both in the proposed rule, as well as this final rule, however, we included costs for facilities to meet the 24/7 RN requirement during all of year 2 (12–24 months) after the date of publication, or 1 year before the requirement went into effect. We included costs for facilities prior to the requirement date to acknowledge that facilities will likely need to hire RNs for this requirement before 2 years after the date of publication, rather than instantaneously hiring them 2 years after the date of publication. We appreciate the commenter bringing this issue to our attention and have provided this clarification below in the detailed economic analysis.

Finally, we acknowledge that costs could in theory be much lower than we estimated if, as suggested by some commenters, facilities transitioned away from LPNs/LVNs when hiring nurses to meet the proposed requirements. We would note, however, that there are transition costs of hiring and firing that have not been quantified. We would also note that facilities have the option to use any nurse staff type, including LPNs/LVNs, to meet the 3.48 total nurse staff HPRD requirement included in the final rule, which would reduce any incentive to transition from LPNs/LVNs to NAs and our intent is for facilities already meeting the minimum staffing requirements not to scale down or adjust staffing types as a result of this rule. As such, we believe that there is a low likelihood that facilities will

<sup>107</sup> Federal Reserve Bank of Minneapolis. Inflation Calculator. Accessed February 26, 2024. <https://www.minneapolisfed.org/about-us/monetary-policy/inflation-calculator>.

<sup>108</sup> 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.

transition away from LPNs/LVNs to meet the requirements in this rule and of course, expect that facilities will not lay off staff necessary to serve patients with their existing case mix. We do not believe that we could accurately predict facility behaviors with respect to LPNs/LVNs. Due to the role that LPNs/LVNs can play in meeting the 3.48 HPRD requirement and the related reduced likelihood of nursing homes ending employment of LPNs/LVNs in light of this policy change, it would understate the effects of the final rule to attempt to reduce overestimation of effects of the rule as proposed and thus we have decided to retain our assumption that facilities will retain LPNs/LVNs at their current level. Given these factors, we are retaining our estimation methodology as we believe it provides an accurate estimate of the rule's estimated economic cost. We would note, however, that we have modified the formula to estimate the cost over 10 years since in the proposed rule the cost estimate provided for the alternative policies that we are now finalizing was based on the 3.48 HPRD requirement going into effect the same time as the 0.55 RN HPRD and 2.45 NA HPRD requirements. Since this final rule requires facilities located in urban areas to meet the 3.48 HPRD requirement 2 years following publication of this rule, which is 1 year prior to the implementation date of the 0.55 RN HPRD and 2.45 NA HPRD requirements, and for rural facilities to meet the 3.48 HPRD requirement 2 years prior to the implementation date of the 0.55 RN and 2.45 NA HPRD requirements, we modified the formula to take into account that nurse staff hired to meet the 3.48 total nurse HPRD requirement can also count toward meeting the individual NA requirement that will be implemented in future years. We detail these changes below in the detailed economic analysis section.

*Comment:* Multiple commenters provided feedback on other effects apart from increased costs and the need to hire new nurse staff that would emerge from the staffing requirements. Some commenters said that nursing homes may lay off non-nurse staff members and cut resident activities, such as bingo night, which contribute to patients' quality of life, to fund the requirements since nursing homes are already struggling financially with the rising costs of inflation, food, insurance, and an already increased payroll. One commenter stated that the rule may also increase operating expenses more generally. Other commenters expressed concern that without additional

Medicare and Medicaid funding, which varies by state, the rule could result in access to care issues, especially in rural and underserved communities. Specifically, commenters noted that the staffing requirements' costs could lead some facilities to close and other facilities to limit the numbers of residents they admit due to insufficient nurse staff to accept more residents. Commenters stated that this effect would likely be higher for nursing homes with a larger share of residents utilizing Medicaid, which are more likely to need to hire staff to meet one or more of the requirements, as well as nursing homes in rural areas that may have difficulty attracting nurse staff or contract employees. Commenters noted that for some rural communities, the closure of facilities could have far reaching impacts on the community leading individuals to leave or forcing nurse home employees to commute long distance to other cities for work, negatively impact the local economy and community life. Commenters suggested analyzing potential bed losses due to the rule, which in turn, could have adverse effects on hospitals who would be unable to discharge patients, leaving them with less space for new patients and increasing the government's cost for patients whose care was covered by Medicare or Medicaid. Commenters also suggested it could have a negative impact on other health care facilities, such as inpatient rehabilitation facilities, which could see greater struggles to find nursing home bed space for their patients. Commenters noted that facility closures could lead residents to be placed further away from the families negatively impacting their overall well-being, or alternatively, nursing homes could pass on the cost to consumers reducing consumers' savings and leading them to use Medicaid. Commenters also suggested that nursing homes may stop accepting patients using Medicaid due to low reimbursement rates, negatively impacting patients who utilize Medicaid.

Other commenters challenged the idea that the rule will be a burden for facilities. They stated that many facilities are diverting funds away from resident care and toward corporate profits. As such, commenters suggested that CMS should not assume that facilities will have challenges meeting the staffing standard and additional actions should be taken to create transparency regarding facility spending. Some commenters expressed concern that phasing-in the nurse staffing requirements would negatively

impact patients and staff members, specifically that phasing-in the requirements means a delay in improved quality of care for residents negatively affecting their health, safety, and quality of life. Commenters also suggested that low staffing levels will lead to continued employee burnout, making them more likely to quit resulting in increased difficulty for facilities to meet the requirements. Finally, multiple commenters noted that the rule does not include increased Medicare or Medicaid reimbursement rates for nursing home residents and that current reimbursement rates have not kept pace with rising costs in recent years. These commenters said that Medicaid reimbursement rates should be increased to ensure access to care and to pay staff a wage that can support a family. Other commenters noted that there is wide variation in Medicaid reimbursement rates across states and asked CMS to consider how this variation will impact facilities' ability to meet the requirements. Finally, some commenters said that they would be forced to hire agency staff at an inflated cost with no guarantee of quality care or positive patient outcomes.

*Response:* We appreciate the thoughtful and insightful comments regarding additional effects that could emerge from the staffing rule. CMS requires facilities to provide appropriate staffing and extracurricular activities to ensure the highest quality of care for residents in accordance with resident assessment, care plans, and resident preferences (see existing requirements at § 483.24(c)). In developing this rule, we sought to ensure resident health and safety while also maintaining access to care. While CMS agrees with commenters highlighting that phasing-in the requirements could lead to a delay in residents receiving higher quality care, as well as continued staff burnout, these effects are difficult to quantify and must be balanced with challenges associated with more rapid implementation of these requirements. As such, we have maintained our regulatory approach that phases in the different staffing requirements over 5 years.

Taken broadly, access to care comments addressed two main issues: finding sufficient staff and the cost for hiring staff. According to the U.S. Bureau of Labor Statistics, in 2022 there were 3,072,700 RNs in the United States.<sup>109</sup> As finalized, the rule would

<sup>109</sup> U.S. Bureau of Labor Statistics. Occupational Employment and Wages, May 2022: 29-1141 Registered Nurses. Accessed February 26, 2024. <https://www.bls.gov/oes/current/oes291141.html>.

require the hiring of approximately 16,000 RNs to meet both the 24/7 RN requirement and the 0.55 RN HPRD requirement. This is approximately 0.5 percent of all non-self-employed RNs in the labor force. HRSA's National Center for Health Workforce Analysis uses a Health Workforce Simulation Model to project the supply and demand for health workers, including RNs.<sup>110</sup> The National Center projects a 10 percent shortage of RN in 2026 and 2031, that will be reduced to 9 percent by 2036.<sup>111</sup> Projected supply adequacy of RNs varies considerably across States, ranging from a shortage of 29 percent in Georgia to a projected 42 percent oversupply in North Dakota in 2036.

Hiring necessary for facilities to meet the NA HPRD requirement will represent a larger portion of NAs available nationwide, and this rule has taken three steps to minimize the impact on access to care and to prevent the closure of facilities due to inadequate staff availability.

The first is to allow facilities located in areas with nurse staff shortages to apply for an exemption from the staffing requirements. Facilities located in areas with nurse staff shortages, as defined in the regulatory text at § 483.35(h), are eligible for exemptions that include: an 8-hour per day exemption from the 24/7 RN requirement, an exemption from the 0.55 RN HPRD requirement, an exemption from the 2.45 NA HPRD requirement, and an exemption from the 3.48 total nurse staff HPRD requirement. These exemptions could reduce both the rule's cost as well as the number of nurse staff needed helping to ensure continued access to care. Based only on being located in an area with nurse staff shortage, a preliminary analysis of the data suggests that more than 29 percent of facilities would be eligible for an 8-hour exemption from the 24/7 RN requirement and the 0.55 RN HPRD requirement, 23 percent of facilities would be eligible for an exemption from the 2.45 NA HPRD requirement, and 22 percent of facilities would be eligible for an exemption from the total nurse staff requirement. Among rural facilities, more than 67 percent of facilities would be eligible for an 8-hour exemption from the 24/7 RN requirement and a total exemption from the 0.55 RN HPRD requirement, 19 percent would be

eligible for an exemption from the 2.45 NA HPRD requirement, and 40 percent would be eligible for an exemption from the 3.48 total nurse staff HPRD requirement. Since facilities would also need to meet all other requirements to obtain an exemption, however, these numbers are not reflective of the number of facilities estimated to fully qualify for the exemptions as they only describe the number of facilities that would satisfy the workforce availability criterion. Second, CMS is launching an initiative to provide over \$75 million in financial incentives, such as scholarships and tuition reimbursement, to make it easier for nurses to enter careers in nursing homes. CMS is also exploring the potential to provide additional technical assistance to LTC facilities regarding staffing through the Quality Improvement Organizations. Finally, rather than requiring facilities to immediately meet the staffing requirements, we have taken a phased-in approach to the requirements to help ensure that an adequate workforce is available and to reduce the cost. For facilities located in urban areas, the requirements will be phased in over 3 years. Specifically, these facilities will have 2 years to comply with the 3.48 total nurse HPRD and the 24 hours per day, 7 days a week RN requirement and have 3 years to comply with the 0.55 RN and 2.45 NA HPRD requirements. For facilities located in rural areas, requirements will be phased in over 5 years. Specifically, these facilities will have 3 years to comply with the 3.48 total nurse HPRD and the 24 hours per day, 7 days per week RN requirement and will have 5 years to comply with the 0.55 RN and 2.45 NA HPRD requirements. While we view the exemptions and the phasing in of the nurse staff requirements as necessary to ensure access to care, we acknowledge that they do come with negative effects for residents and staff. Specifically, exemptions and phasing in of the individual staffing requirements will result in residents residing in nursing homes, which are not currently meeting these requirements, in receiving either less nurse care or a longer delay in receiving the full hours of care per day. Similarly, nursing home staff may experience a heavier workload, leading to higher burnout. As such, we believe that there will be minimum negative impact on workforce availability throughout the care continuum, minimal impact on nursing home bed availability, and minimal increased costs for Medicare and Medicaid due to hospitals being unable to discharge patients.

We note that Medicare and Medicaid payment rates for nursing home care are outside the scope of this rule. With regards to a SNF-specific wage index, we refer commenters to the text regarding this issue and its feasibility on page 61411 in the proposed rule (88 FR 61410). Specifically, 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 IPPS hospitals. We continue to believe that the development of such an audit process could improve SNF cost reports in such a manner as to permit us to establish a SNF-specific wage index, but we do not believe this undertaking is feasible at this time (88 FR 53212).

Finally, while some commenters have questioned whether agency contract staff will increase quality care or positive patient outcomes and said that they may be forced to hire any available staff to meet the requirement, we would note that all nurse staff are required to meet applicable state requirements to be a nurse and are able to have a positive impact on patient health and quality of care. We would continue to encourage facilities to ensure that they are utilizing contract staff in a manner that best improves patient care. In addition, all other requirements governing LTC facilities continue to apply, and we expect facilities to deliver safe and high-quality care to all residents, regardless of the employment arrangement that nursing home use to procure staff.

*Comment:* A few commenters, including the Small Business Administration's Office of Advocacy, suggested that CMS erroneously certified that the rule will not have a

<sup>110</sup> Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at <https://data.hrsa.gov/topics/health-workforce/workforce-projections>. April 2024.

<sup>111</sup> Nurse Workforce Projections, 2021-2036 (hrsa.gov) <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nursing-projections-factsheet.pdf>. March 2024.

significant economic impact on a substantial number of small entities and is violating the Regulatory Flexibility Act (RFA), which 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. Specifically, commenters pointed to an outside analysis by CLA estimating that the rule's actual annual cost will be closer to \$6.8 billion when all requirements are in effect and when compared to revenues for skilled nursing facilities (NAICS 6231) and intellectual and developmental disabilities facilities (NAICS 6232) from the 2017 Economic Census, would exceed the 3 to 5 percent threshold that HHS qualifies as economically significant. They also noted that the CMS should have included other LTC facilities that rely on nurses in the RFA certification. These include residential mental health and substance abuse facilities (NAICS 62322), Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly (NAICS 6233), Continuing Care Retirement Communities (NAICS 623311), Other Residential Care Facilities (NAICS 62399), and Services for the Elderly and Person with Disabilities (NAICS 62412). Finally, they noted that costs should have been analyzed on a per small entity basis to make it easier to understand the rule's true impact.

*Response:* We appreciate the comments provided. We have discussed in detail in our comment response above regarding our estimated cost, and why we think that our estimate provides a more accurate calculation of the likely cost, and henceforth, are using it as the basis for our conclusion. In summary, the higher estimate from CLA uses median wages for nursing homes, which are not data that are publicly available and do not appear on Medicare cost reports, it does not appear to include hours worked by contract employees in the estimates, and it calculates costs in 2022 US dollars while we calculate costs in 2021 US dollars. Meanwhile, the higher estimate from Leading Age appears to calculate costs based on daily nurse staff levels and assumes that nursing homes would not reassign staff to different days in the week to meet the requirements and provides estimates in 2023 US dollars. We would also note that while one commenter indicated the wages from the CLA estimate were from 2023 when wages were higher, this is not the case. Rather, as the CLA document provided indicates, this \$6.8 billion cost estimate is based on a combination of facility wage data from

2021 and 2022. We believe that they confused the Leading Age and CLA estimates.

The rule also includes exemptions for facilities that are located in areas with nurse staff shortages that would allow facilities to receive an 8 hour a day exemption from the 24/7 RN requirement, as well as exemptions from the 0.55 RN HPRD requirement, the 2.45 NA requirement, and the 3.48 total nurse staff HPRD requirement. These exemptions could reduce both the rule's cost as well as the number of staff that will need to be hired and thus help supported continued access to care. Given these changes in the requirements, we maintain our certification that this final rule will not have a significant economic impact on a substantial number of small entities and do not analyze options for regulatory relief of small entities beyond the exemptions we have already finalized in this rule.

With regards to the per facility analysis, we would note that the proposed rule provided multiple per facility cost analyses for facilities needing staff by state that include costs for (1) rural compared to urban facilities, (2) facilities of different sizes (<50 beds, 50 to 100 beds, and >100 beds, and (3) Medicare, Medicaid, and Dual Acceptance Status. We would also note that analyzing the cost on a per facility basis would lead to the same percentage as we have estimated, since costs were calculated based on all facilities.

We appreciate some commenters noting that our estimates of share of revenues were based on 2017 dollars that do not take into account cost increases. Therefore, to more accurately, estimate the estimated costs as a share of revenues, we take into account increases in the Consumer Price Index to more accurately measure annual revenues, which results in annual revenues rising to approximately \$179 billion in 2021 US dollars. We also appreciate the suggestion to include other long term care facilities that rely on nurses in the analysis. We believe, however, that the impact on these other facility types would be minimal since the requirements of this rule do not apply to these other facility types. Moreover, we would note that including these additional facility types, with the exception of "other residential care facilities" that do not utilize significant amounts of nursing staff, in the analysis would increase total revenues for affected industries to approximately \$275 billion in 2021 US dollars, which would not change the analysis that the rule does not have a significant

economic impact on a substantial number of small entities.

*Comment:* A few commenters expressed concern that CMS erroneously certified that the rule did not violate the Unfunded Mandates Reform Act (UMRA) since Tribal governments own nursing homes that this rule would affect.

*Response:* We recognize that Tribal governments own nursing homes, as do states and local governments. As we have noted in the regulatory impact analysis for the proposed rule, this rule does not require Tribal governments to provide additional financial resources to meet any of the staffing requirements in this rule. As such, we maintain our certification that the rule will not impose new requirements for Tribal governments.

*Comment:* A few commenters stated that CMS violated Federal law by not engaging in meaningful discussion or consult with Tribes before releasing the proposed regulation that affects tribally operated nursing homes in Indian Country. They indicate that CMS seems to have ignored detailed comments that Tribal leaders and the CMS Tribal Technical Advisory Group (TTAG) submitted in response to CMS' Request for Information last year.

*Response:* Consistent with the CMS Tribal Consultation Policy, CMS seeks the guidance of Tribal leaders on the delivery of health care for American Indians/Alaska Natives (AI/AN) served by the Marketplace, Medicare, Medicaid, Children's Health Insurance Program, or any other health care program funded by CMS. We believe that we have followed the CMS Tribal Consultation Policy by engaging in meaningful discussions on this regulation that affects tribally-operated nursing homes. CMS reviewed and took into consideration all comments provided in the FY 2023 SNF PPS RFI, including those comments specific to the impact of any staffing rule on Tribal nursing homes. As we outlined in the proposed rule, we held two listening sessions on June 27, 2022, and August 29, 2022, to allow all stakeholders, including those with concerns about the impact that a staffing standard will have on tribally-owned nursing homes, the opportunity to provide feedback on the approach utilized for establishing a minimum staffing standard (88 FR 61364). In addition, we attended the CMS Tribal Technical Advisory Group (TTAG) quarterly meeting on October 18–19, 2023, to provide an overview of the NPRM and respond to questions and comments from the TTAG. We encouraged the TTAG to submit written comments as outlined in the proposed

rule and we have reviewed and considered those comments in issuing this final rule. Consistent with the government-to-government relationship, CMS is available to continue its dialogue with Tribal governments and the CMS TTAG and to provide technical assistance as needed in the implementation of this rule impacting Tribal nursing homes.

*Comment:* One commenter noted that they believe that this policy has federalism implications and should be subject to applicable federalism requirements since the 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. They also note that facilities would be required to meet applicable state and Federal staffing laws and that CMS failed to consult with state agencies and other organizations in violation of section 3(b) of Executive Order 13132.

*Response:* As we noted in the federalism analysis section, 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 final 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 finalized in this rule or from meeting higher staffing levels required based on the facility assessment provisions finalized in this rule. As we outlined in the proposed rule (88 FR 61364), we held two listening sessions on June 27, 2022, and August 29, 2022, to allow all stakeholders, including state agencies and other organizations to voice their concerns about the impact that a staffing standard, and took into consideration comments provided by state agencies.

### C. Detailed Economic Analysis

#### 1. Impacts for LTC Minimum Staff Requirement

##### a. Nursing Services (§ 483.35)

We are finalizing two changes to the existing requirements for Nursing

Services for LTC facilities at § 483.35. We are requiring 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, 2.45 NA, and 3.48 HPRD for total nurse staffing. We note that these estimates do not include adjustments for any exemptions that we may provide, 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 frequency of exemptions.

##### (1). RN Onsite 24 Hours a Day, 7 Days a Week (24/7 RN)

To estimate the cost to the industry of full implementation of the requirement that a facility have an RN on site 24 hours a day, 7 days a week (24/7 RN), 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 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 mean annual salaries, defined as salary and fringe benefits. Specifically, we calculated mean hourly wages for both employees and agency staff by using Column 3 in Worksheet S-3, Part V and dividing it by the sum of reported paid hours for RNs using data from Column 4 in Worksheet S-3, Part V.<sup>112</sup> For nursing homes with missing or extreme values for hourly wages, we imputed the wage rate based on the state-level weighted hourly wage of non-outlier nursing homes within the state. Using this dataset, we were able to estimate the aggregate RN loaded salary costs and the cost per facility, including the cost for contract RNs.

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 mean 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

<sup>112</sup> The cost report data utilized were from October 18, 2022, and are available at <https://www.cms.gov/httpswwwcmgovresearch-statistics-data-and-systemsdownloadable-public-use-filescostreports/2021-1>.



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 the 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 final rule, as well as broader patterns of healthcare use in the United States. A 2009 study<sup>113</sup> 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<sup>114</sup> 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 will 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 \$366 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	\$24,440,832.00	\$0.00	\$0.00	\$24,440,832.00
2	\$25,005,415.00	\$213,764,107.41	\$0.00	\$238,769,522.41
3	\$25,583,040.00	\$218,702,058.29	\$146,603,030.04	\$390,888,128.33
4	\$26,174,009.00	\$223,754,075.83	\$149,989,560.03	\$399,917,644.86
5	\$26,778,628.00	\$228,922,794.98	\$153,454,318.87	\$409,155,741.85
6	\$27,397,214.00	\$234,210,911.55	\$156,999,113.64	\$418,607,239.19
7	\$28,030,090.00	\$239,621,183.61	\$160,625,793.16	\$428,277,066.77
8	\$28,677,585.00	\$245,156,432.95	\$164,336,248.98	\$438,170,266.93
9	\$29,340,037.00	\$250,819,546.55	\$168,132,416.34	\$448,291,999.89
10	\$30,017,792.00	\$256,613,478.07	\$172,016,275.15	\$458,647,545.22
<b>10 Year Total Cost</b>	<b>\$271,444,644</b>	<b>\$2,111,564,589</b>	<b>\$1,272,156,756</b>	<b>\$3,655,165,989.00</b>

(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 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 will need to hire to meet the finalized 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 will 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 *Nursing Home Care Compare* data set that provides each nursing home’s average daily resident census and HPRD for RNs using the PBJ system data for 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 has 100 residents and provides 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

<sup>113</sup> Mark B, Harless DW, and Spetz J. California’s Minimum-Nurse Staffing Legislation and Nurses’ Wages. *Health Affairs*. 2009;28 Supplement 1, w326-w334. doi: 10.1377/hlthaff.28.2.w326.

<sup>114</sup> 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.

of hours of yearly care provided by a full-time RN. Continuing with our example in this section, the nursing home will 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 that LTC facilities will need to hire, and the

percent increase in RNs that LTC facilities in each State will need to meet the proposed minimum staffing standard barring any exemptions. Oklahoma will 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 will be in Louisiana at 17.6 percent. Facilities in Texas will 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 will 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.

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State	Existing Full-Time RNs in Rural Areas	Additional RNs Needed in Rural Areas	% Increase in RNs Needed in Rural Areas	Existing Full-Time RNs in Urban Areas	Additional RNs Needed in Urban Areas	% Increase in RNs Needed in Urban Areas
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
<b>United States</b>	<b>26,708</b>	<b>1,358</b>	<b>5.1</b>	<b>108,220</b>	<b>1,909</b>	<b>1.8</b>

State	Existing Full-Time RNs in Rural Areas	Additional RNs Needed in Rural Areas	% Increase in RNs Needed in Rural Areas	Existing Full-Time RNs in Urban Areas	Additional RNs Needed in Urban Areas	% Increase in RNs Needed in Urban Areas
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
<b>United States</b>	<b>26,708</b>	<b>1,358</b>	<b>5.1</b>	<b>108,220</b>	<b>1,909</b>	<b>1.8</b>

We then assessed the financial cost for facilities to implement the 24/7 RN requirement. To estimate the yearly cost per State, we used the formulas described in section VI.C.1.(a) of this 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 will 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 will 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 will need to hire additional staff to meet the requirement. Delaware has the highest cost per resident day with a single facility that is not meeting the 24/7 RN requirement and will need to spend \$87.45 per

resident day. The highest overall cost occurs in Texas where facilities will 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 will need to spend an average of \$8.95 per resident day to meet the requirement, while in Hawaii, Puerto Rico, and Wyoming these facilities will occur no cost. Nevada will 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
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	\$0.0	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

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)
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			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 will 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 will be \$0.72, while in North Carolina, the average cost per resident

day for facilities with fewer than 50 beds will 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)**

	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
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

	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
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	3,267	\$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 will be for 14 Medicaid-only facilities in Illinois that will 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 will be for a single Medicaid-only facility in South

Dakota that will 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
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

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
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 3.48 Total Nurse Staffing HPRD, 0.55 RN HPRD, and 2.45 NA HPRD

To estimate the incremental impact of the minimum nurse staffing requirement requirements of 2.45 NA HPRD, 0.55 RN HPRD, and 3.48 total nurse staffing 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 these requirements. We note that these HPRD 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 these requirements, regardless of the facility's case-mix. Finally, we calculated the requirements' 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 requirements (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 mean 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, including the cost for contract staff.

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  $\times$  [facility specific nurse type] reported HPRD  $\times$  facility-level average daily facility resident census  $\times$  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:  $\$44 \times 0.4 \times 100 \times 365 = \$642,400$ . 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:  $\$21 \times 2.1 \times 100 \times 365 = \$1,609,650$ . 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.

#### c. 3.48 Total Nurse Staffing Requirement

To estimate the cost of the 3.48 total nurse staffing HPRD requirement, we subtracted the total current nurse staffing cost per facility from the total nurse staffing cost per facility with the 3.48 total nurse staffing HPRD standard. For the purpose of the cost estimates, we continue the assumption stated in the proposed rule that facilities would hire NAs to meet the total nurse staffing requirement. The formula applied to calculate each facility's cost of meeting of meeting the requirement was:  $[(3.48 \text{ total nurse staffing HPRD}) - [\text{facility specific reported total nurse staffing HPRD}]] \times \text{facility specific NA hourly}$

wage  $\times$  facility level average daily resident census  $\times$  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, this LTC facility would have a total of 2.5 ( $0.4 + 2.1 = 2.5$ ) total nurse staffing HPRD. To comply with the requirement, it would need to increase its NA HPRD from 2.1 to 3.08 adding an additional 0.98 ( $3.48 - 2.5 = 0.98$ ) HPRD. The cost for this requirement on this facility would thus be  $\$751,170$  ( $[(3.48 - 2.5) \times \$21 \times 100 \times 365] = \$751,170$ ).

When LTC facilities hire RNs to meet the 24/7 RN requirement, which goes into effect the same year as the 3.48 total nurse staffing HPRD requirement, the hours these RNs work will also count toward the 3.48 total nurse staffing HPRD requirement. To avoid overestimating the number of nurse staff that LTC facilities will need to hire to meet the 3.48 total nurse staffing requirement and the cost to hire them, if a LTC facility has less than 3.48 total nurse staff HPRD, we subtracted any staff hours that the facility will need to meet the 24/7 RN requirement up to the point where the LTC facility will meet the 3.48 total nurse staff HPRD requirement.

After accounting for any increase in RN hours per resident day to meet the 24/7 RN requirement, 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:  $[3.48 - (\text{RN HPRD} + \text{LVN/LPN HPRD} + \text{NA HPRD})]$ . For any facilities that were below the 3.48 total nurse staff HPRD requirement, we assumed that they would hire NAs to fulfill any remaining hours.

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 \$1.37 billion. To factor in the 2.31 percent increase in real increase in wage rates and the different timeline for rural and urban facilities to meet these requirements, in table 20 we provide the estimated cost annually and over 10 years. Overall, we estimate that the requirement will cost an average of approximately \$1.36 billion annually and \$13.64 billion over 10 years.

**Table 20: Annual and 10 Year Cost of 3.48 Total Nurse Staff HPRD Requirement**

Year	Rural Facilities	Urban Facilities	All Facilities
Year 1	\$0	\$0	\$0
Year 2	\$0	\$1,157,240,099	\$1,157,240,099
Year 3	\$253,983,202	\$1,183,972,345	\$1,437,955,547
Year 4	\$259,850,214	\$1,211,322,106	\$1,471,172,320
Year 5	\$265,852,754	\$1,239,303,647	\$1,505,156,401
Year 6	\$271,993,953	\$1,267,931,561	\$1,539,925,514
Year 7	\$278,277,013	\$1,297,220,780	\$1,575,497,793
Year 8	\$284,705,212	\$1,327,186,580	\$1,611,891,792
Year 9	\$291,281,902	\$1,357,844,590	\$1,649,126,493
Year 10	\$298,010,514	\$1,389,210,800	\$1,687,221,314
10 Year Total Cost	\$2,203,954,765	\$11,431,232,508	\$13,635,187,273

c. Minimum Nurse Staffing Requirement of 0.55 RN and 2.45 NA HPRD

When LTC facilities hire RNs to meet the 24/7 RN requirement, which goes into effect before the 0.55 RN HPRD 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 meets the 0.55 RN HPRD requirement with current staff including RNs hired for the 24/7 RN requirement, we estimate that its cost is \$0. For facilities that still need to hire RNs to meet the 0.55 RN HPRD requirement we calculate costs using the

following formula:  $[[0.55 \text{ RN HPRD}] - [\text{facility specific RN HPRD} + \text{facility specific RN HPRD resulting from 24/7 RN requirement}]] \times \text{facility specific RN hourly wage} \times \text{facility level average daily resident census} \times 365$ . Similarly, When LTC facilities hire NAs to meet the 3.48 total nurse staff HPRD requirement, which goes into effect before the 2.45 NA HPRD requirement, the hours these NAs work will also count toward the 2.45 NA HPRD requirement. To avoid overestimating the number of NAs that LTC facilities will need to hire and the cost to hire them, if a LTC facility meets the 2.45 NA HPRD requirement when including NAs hired to meet the 3.48 total nurse

staff HPRD requirement, we estimate that its cost is \$0. For facilities that still need to hire NAs to meet the 2.45 NA HPRD requirement we calculate costs using the following formula:  $[[2.45 \text{ NA HPRD}] - [\text{facility specific NA HPRD} + \text{facility specific NA HPRD resulting from 3.48 total nurse staff requirement}]] \times \text{facility specific NA hourly wage} \times \text{facility level average daily resident census} \times 365$ .

In table 21, we provide the estimated cost annually and over 10 years for the 0.55 RN and 2.45 NA HPRD requirements. These requirements have a total cost of approximately \$2.54 billion annually and \$25.38 billion over 10 years.

**Table 21: Annual and 10 Year Cost of 0.55 RN and 2.45 NA HPRD Requirements**

Year	Rural Facilities	Urban Facilities	All Facilities
Year 1	\$0	\$0	\$0
Year 2	\$0	\$0	\$0
Year 3	\$0	\$2,524,018,922	\$2,524,018,922
Year 4	\$0	\$2,582,323,759	\$2,582,323,759
Year 5	\$546,905,194	\$2,641,975,437	\$3,188,880,632
Year 6	\$559,538,704	\$2,703,005,070	\$3,262,543,774
Year 7	\$572,464,048	\$2,765,444,487	\$3,337,908,535
Year 8	\$585,687,968	\$2,829,326,255	\$3,415,014,222
Year 9	\$599,217,360	\$2,894,683,691	\$3,493,901,051
Year 10	\$613,059,281	\$2,961,550,885	\$3,574,610,165
10 Year Total Cost	\$3,476,872,554	\$21,902,328,505	\$25,379,201,060

Table 22 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, for each requirement we continue to assume that real wages for nurse staff, as well as collection of information costs, will

increase at 2.31 percent annually. Since rural and urban LTC facilities have different phase-in periods to meet the 24/7 RN and 3.48 total nurse staff HPRD requirement (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 \$4.3 billion.

We would note that the estimated \$21.9 billion cost for the 0.55 RN and 2.45 NA HPRD requirements over 10 years differs from the estimated cost of \$36.9 billion in the proposed rule. The reason for this difference is that with the 3.48 HPRD total nurse staff requirement, NAs hired to meet the requirement will also count toward the 2.45 NA HPRD requirement. As such, a large part of this cost difference is reflected in the calculated costs for the 3.48 total nurse staffing requirement.

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**Table 22: 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)	3.48 Total Nurse Staffing Requirement (Urban Facilities)	3.48 Total Nurse Staffing Requirement (Rural Facilities)	0.55 RN and 2.45 NA HPRD Requirements (Urban Facilities)	0.55 RN and 2.45 NA HPRD Requirements (Rural Facilities)	Total Cost
Year 1	\$24,440,832	\$28,494,720	\$0	\$0	\$0	\$0	\$0	\$0	\$52,935,552
Year 2	\$25,005,415	\$29,152,948	\$213,764,107	\$0	\$1,157,240,099	\$0	\$0	\$0	\$1,425,162,569
Year 3	\$25,583,040	\$29,826,381	\$218,702,058	\$146,603,030	\$1,183,972,345	\$253,983,202	\$2,524,018,922	\$0	\$4,382,688,978
Year 4	\$26,174,009	\$30,515,371	\$223,754,076	\$149,989,560	\$1,211,322,106	\$259,850,214	\$2,582,323,759	\$0	\$4,483,929,093
Year 5	\$26,778,628	\$31,220,276	\$228,922,795	\$153,454,319	\$1,239,303,647	\$265,852,754	\$2,641,975,437	\$546,905,194	\$5,134,413,050
Year 6	\$27,397,214	\$31,941,464	\$234,210,912	\$156,999,113	\$1,267,931,561	\$271,993,953	\$2,703,005,070	\$559,538,704	\$5,253,017,991
Year 7	\$28,030,090	\$32,679,312	\$239,621,184	\$160,625,793	\$1,297,220,780	\$278,277,013	\$2,765,444,487	\$572,464,048	\$5,374,362,707
Year 8	\$28,677,585	\$33,434,204	\$245,156,433	\$164,336,249	\$1,327,186,580	\$284,705,212	\$2,829,326,255	\$585,687,968	\$5,498,510,485
Year 9	\$29,340,037	\$34,206,534	\$250,819,547	\$168,132,416	\$1,357,844,590	\$291,281,902	\$2,894,683,691	\$599,217,360	\$5,625,526,077
Year 10	\$30,017,792	\$34,996,705	\$256,613,478	\$172,016,275	\$1,389,210,800	\$298,010,514	\$2,961,550,885	\$613,059,281	\$5,755,475,730
10 Year Total Cost	\$271,444,644	\$316,467,914	\$2,111,564,589	\$1,272,156,753	\$11,431,232,508	\$2,203,954,765	\$21,902,328,505	\$3,476,872,554	\$42,986,022,233

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This final 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 these finalized requirements. Below, however, we provide estimates of how much of the estimated cost is due to residents whose care is covered by three payor groups: Medicaid, Medicare, and other non-Medicare/Medicaid payors.

Table 23 provides annual estimates and a 10-year total estimate for the share of facilities' increased staffing costs that is due to residents utilizing Medicaid. These estimates exclude 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 is approximately \$2.82 billion. If Medicaid were to fully cover these costs (although there is no expectation that it will), then States would pay approximately \$1.17 billion, and the Federal Government would pay \$1.65 billion.

To build these estimates, we used a scenario where each facility's increased cost to meet the new minimum staffing and 24/7 RN requirements for residents utilizing Medicaid is equal to share of residents in the facility using Medicaid. More formally, we first calculated each facility's increased staffing cost for residents utilizing Medicaid for each of

the four requirements (24/7 RN, 3.48 total nurse staff, 0.55 RN HPRD, and 2.45 NA HPRD) using the following formula: Increased Facility Cost for Medicaid Residents = Individual requirement cost  $\times$  % facility residents covered by Medicaid. We then summed all facilities' increased costs that is due to residents utilizing Medicaid and took into account the different timeline for each of the requirements to obtain a total estimated cost for Medicaid of \$28.17 billion over 10 years.

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**Table 23: Impact of Comprehensive Minimum Nurse Staffing Requirement on Medicaid Spending**

Year	24/7 RN State Medicaid Costs (Rural Areas)	24/7 RN State Medicaid Costs (Urban Areas)	24/7 RN Federal Medicaid Costs (Rural Areas)	24/7 RN Federal Medicaid Costs (Urban Areas)	3.48 Total Nurse HPRD Requirement State Medicaid Costs (Rural Areas)	3.48 Total Nurse HPRD Requirement State Medicaid Costs (Urban Areas)	3.48 Total Nurse HPRD Requirement Federal Medicaid Costs (Rural Areas)	3.48 Total Nurse HPRD Requirement Federal Medicaid Costs (Urban Areas)	0.55 RN and 2.45 NA HPRD Requirements State Medicaid Costs (Rural Areas)	0.55 RN and 2.45 NA HPRD Requirements State Medicaid Costs (Urban Areas)	0.55 RN and 2.45 NA HPRD Requirements Federal Medicaid Costs (Rural Areas)	0.55 RN and 2.45 NA HPRD Requirements Federal Medicaid Costs (Urban Areas)	Total State Medicaid Costs	Total Federal Medicaid Costs
1	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2	\$0	\$53,154,964	\$0	\$81,910,452	\$0	\$351,968,339	\$0	\$462,098,986	\$0	\$0	\$0	\$0	\$405,123,303	\$544,009,439
3	\$35,749,826	\$54,382,844	\$60,811,000	\$83,802,584	\$67,959,241	\$360,098,808	\$104,952,272	\$472,773,473	\$0	\$682,438,857	\$0	\$943,625,739	\$1,200,629,576	\$1,665,965,068
4	\$36,575,647	\$55,639,088	\$62,215,734	\$85,738,424	\$69,529,099	\$368,417,090	\$107,376,669	\$483,694,540	\$0	\$698,203,195	\$0	\$965,423,494	\$1,228,364,119	\$1,704,448,861
5	\$37,420,545	\$56,924,350	\$63,652,917	\$87,718,981	\$71,135,222	\$376,927,525	\$109,857,070	\$494,867,884	\$136,832,797	\$714,331,688	\$231,945,474	\$987,724,777	\$1,393,572,127	\$1,975,767,103
6	\$38,284,959	\$58,239,303	\$65,123,300	\$89,745,290	\$72,778,445	\$385,634,551	\$112,394,769	\$506,299,332	\$139,993,635	\$730,832,750	\$237,303,414	\$1,010,541,219	\$1,425,763,644	\$2,021,407,324
7	\$39,169,342	\$59,584,631	\$66,627,648	\$91,818,406	\$74,459,627	\$394,542,709	\$114,991,088	\$517,994,847	\$143,227,488	\$747,714,987	\$242,785,123	\$1,033,884,721	\$1,458,698,784	\$2,068,101,833
8	\$40,074,154	\$60,961,036	\$68,166,747	\$93,939,411	\$76,179,645	\$403,656,645	\$117,647,382	\$529,960,528	\$146,536,043	\$764,987,203	\$248,393,459	\$1,057,767,458	\$1,492,394,726	\$2,115,874,985
9	\$40,999,867	\$62,369,236	\$69,741,399	\$96,109,411	\$77,939,395	\$412,981,114	\$120,365,037	\$542,202,616	\$149,921,026	\$782,658,408	\$254,131,348	\$1,082,201,887	\$1,526,869,044	\$2,164,751,697
10	\$41,946,963	\$63,809,965	\$71,352,425	\$98,329,539	\$79,739,795	\$422,520,978	\$123,145,469	\$554,727,496	\$153,384,201	\$800,737,817	\$260,001,782	\$1,107,200,750	\$1,562,139,719	\$2,214,757,461
10 Year Total Cost	\$310,221,303	\$525,065,417	\$527,691,169	\$809,112,498	\$589,720,469	\$3,476,747,758	\$910,729,756	\$4,564,619,703	\$869,895,190	\$5,921,904,905	\$1,474,560,601	\$8,188,370,045	\$11,693,555,041	\$16,475,083,771

Table 24 provides annual estimates of facilities' increased staffing costs that is due to residents whose care is covered by Medicare and other non-Medicare/Medicaid payors. These estimates and a 10-year estimate for the share of

continue to exclude all collection of information costs. Over a 10-year period, facilities' average annual cost to meet the proposed requirements will be approximately \$471 million for residents utilizing Medicare and \$921 million for residents utilizing other non-Medicare/Medicaid payors.

To build these estimates, we used a scenario where the cost each facility will incur to meet the new minimum staffing and 24/7 RN requirements for residents utilizing Medicare is equal to the share of residents covered by Medicare and non-Medicare/Medicaid payors in each facility. More formally, we first calculated each facility's increased staffing cost for residents

utilizing Medicare and other non-Medicare/Medicaid payors for each of the four requirements (24/7 RN, 3.48 total nurse staff, 0.55 RN HPRD, and 2.45 NA HPRD) using the following formula: Increased Facility Cost for Medicare Residents = Individual requirement cost  $\times$  % facility residents covered by Medicare. We then summed all facilities' increased costs that is due to residents utilizing Medicare and took into account the different timeline for each of the requirements to obtain a total estimated cost to facilities for Medicare-covered SNF stays of \$4.71 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 staffing cost for residents utilizing other non-Medicare/Medicaid payors for each of the four requirements (24/7 RN, 3.48 total nurse staff HPRD, 0.55 RN HPRD, and 2.45 NA HPRD) using the following formula: Increased Facility Cost for Non-Medicare/Medicaid Payors = Individual requirement cost  $\times$  % facility residents covered by non-Medicare/Medicaid Payors. We then summed all facilities' increased costs that is due to residents utilizing other Non-Medicare/Medicaid payors and took into account the different timeline for each of the requirements to obtain a total estimated cost of \$9.21 billion over 10 years.

**Table 24: 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 Costs (Rural Facilities)	24/7 RN Medicare Costs (Urban Facilities)	3.48 Total Nurse HPRD Requirement Medicare Costs (Rural Facilities)	3.48 Total Nurse HPRD Requirement Medicare Costs (Urban Facilities)	0.55 RN and 2.45 NA HPRD Requirements Medicare Costs (Rural Facilities)	0.55 RN and 2.45 NA HPRD Requirements Medicare Costs (Urban Facilities)	24/7 RN Other Non-Medicare / Medicaid Payors' Costs (Rural Facilities)	24/7 RN Other Non-Medicare / Medicaid Payors' Costs (Urban Facilities)	Other Non-Medicare/Medicaid Payors' 3.48 Total Nurse HPRD Requirement Costs (Rural Facilities)	Other Non-Medicare/Medicaid Payors' 3.48 Total Nurse HPRD Requirement Costs (Urban Facilities)	Non-Medicare or Medicaid Payors' 0.55 RN and 2.45 NA HPRD Requirements Costs (Rural Facilities)	Non-Medicare or Medicaid Payors' 0.55 RN and 2.45 NA HPRD Requirements Costs (Urban Facilities)	Total Costs Due to Residents whose Stay is Covered by Medicare	Total Costs Due to Residents whose Stay is Covered by Other non-Medicare/Medicaid Payors
1	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2	\$0	\$25,668,903	\$0	\$110,056,337	\$0	\$0	\$0	\$48,465,732	\$0	\$226,153,246	\$0	\$0	\$135,725,241	\$274,618,978
3	\$12,537,908	\$26,261,855	\$25,809,665	\$112,598,639	\$0	\$305,704,601	\$34,221,940	\$49,585,290	\$54,428,846	\$231,377,386	\$0	\$575,820,709	\$482,912,667	\$945,434,172
4	\$12,827,533	\$26,868,504	\$26,405,868	\$115,199,667	\$0	\$312,766,377	\$35,012,467	\$50,730,710	\$55,686,153	\$236,722,204	\$0	\$589,122,168	\$494,067,949	\$967,273,702
5	\$13,123,849	\$27,489,166	\$27,015,843	\$117,860,779	\$60,626,534	\$319,991,280	\$35,821,255	\$51,902,590	\$56,972,503	\$242,190,486	\$114,509,544	\$602,730,890	\$566,107,453	\$1,104,127,268
6	\$13,427,010	\$28,124,166	\$27,639,909	\$120,583,363	\$62,027,007	\$327,383,079	\$36,648,726	\$53,101,540	\$58,288,568	\$247,785,087	\$117,154,714	\$616,653,973	\$579,184,335	\$1,129,632,608
7	\$13,737,174	\$28,773,834	\$28,278,391	\$123,368,839	\$63,459,831	\$334,945,628	\$37,495,312	\$54,328,185	\$59,635,033	\$253,508,922	\$119,860,988	\$630,898,680	\$592,563,698	\$1,155,727,121
8	\$14,054,503	\$29,438,510	\$28,931,622	\$126,218,659	\$64,925,753	\$342,682,872	\$38,361,453	\$55,583,166	\$61,012,603	\$259,364,978	\$122,629,777	\$645,472,440	\$606,251,919	\$1,182,424,417
9	\$14,379,162	\$30,118,540	\$29,599,943	\$129,134,310	\$66,425,538	\$350,598,846	\$39,247,603	\$56,867,138	\$62,421,994	\$265,356,309	\$125,462,525	\$660,382,853	\$620,256,339	\$1,209,738,421
10	\$14,711,321	\$30,814,278	\$30,283,701	\$132,117,313	\$67,959,968	\$358,697,680	\$40,154,223	\$58,180,768	\$63,863,942	\$271,486,040	\$128,360,709	\$675,637,697	\$634,584,260	\$1,237,683,379
Total 10 Year Cost	\$108,798,460	\$253,557,757	\$223,964,943	\$1,087,137,907	\$385,424,630	\$2,652,770,364	\$296,962,980	\$478,745,120	\$472,309,641	\$2,233,944,658	\$727,978,257	\$4,996,719,410	\$4,711,654,062	\$9,206,660,066

Sources of uncertainty about the cost estimate for the 24/7 RN, 3.48 Total

Nurse Staffing HPRD, 0.55 RN and 2.45 NA HPRD requirements include:

The cost estimates 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,<sup>115 116</sup> 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 respond to the 24/7 RN, 3.48 total nurse staff HPRD, 0.55 RN HPRD, and 2.45 NA HPRD requirements 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 intent of this rule, however, is that facilities will maintain levels of indirect care staff necessary to meet their residents' needs, while also scaling up direct care staff if needed to meet the minimums.

The cost estimates assumed that real wages for RNs and NAs will grow at a real 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 cost estimates assumed that the nursing home resident population will remain stable over the next 10 years. There is some evidence, however, that the resident population is declining. CMS *Care Compare* data shows that between February 2017 and February 2024, the average number of residents in nursing homes per day declined from 1,346,712 residents to 1,207,726.<sup>117</sup> If the resident population continues to decrease, then the costs could be lower than what we have estimated. Similarly, if the pattern changes and the nursing home resident population increases, costs could be higher than what we have estimated.

<sup>115</sup> Thomas, Kali S., Kathryn Hyer, Ross Anzel, 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.

<sup>116</sup> 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.

<sup>117</sup> CMS. (2024). Nursing homes including rehab services archived data snapshots. Accessed March 19, 2024. Available at: <https://data.cms.gov/provider-data/archived-data/nursing-homes>.

The 24/7 RN cost estimate assumed that RNs hired to meet the requirement will make the loaded average hourly rate for RNs in the facility. If, however, LTC facilities need 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 for the 3.48 total nurse staff requirement assumes that facilities will hire NAs to fill the necessary hours. If, however, they hire LPNs/LVNs, then the cost could increase since LPNs/LVNs command a higher hourly wage than NAs.

The cost estimate assumed that no LTC facilities will obtain exemptions from the 24/7 RN requirement, the 3.48 total nurse staffing HPRD requirement, or the 0.55 RN and 2.45 NA HPRD requirements, although some facilities could obtain exemptions. Depending on the number of facilities that obtain exemptions from the requirements and their expected cost to meet the requirements, the total cost of the rule for LTC facilities could be lower than what is estimated.

In addition to uncertainty about the magnitude of costs, there is uncertainty about whether LTC facilities or other payors would bear the cost of meeting the minimum staffing and 24/7 RN requirements. As we highlighted earlier in this RIA, we expect that LTC facilities would generally have 3 possible approaches to addressing the increased costs associated with the higher staffing levels: (1) reduce their margin or profit; (2) reduce other operational costs; and (3) increase prices charged to payors. LTC facilities may use some combination of these approaches, and those approaches could vary by facility and over time. These decisions could depend on a number of factors, including: the current margin levels of a facility; the cost increase due to the staffing requirements relative to current costs and revenues; the current level of operational costs; and the ability to negotiate prices with payors. If payors did increase payment rates to meet some or all the rule's cost, the cost for LTC facilities could be lower relative to what is estimated above.

#### (4). Impact of 3.48 Total Nurse Staff, 0.55 RN, and 2.45 NA HPRD Requirements on States

To provide a more in-depth understanding of the financial and staffing effects of the 3.48 total nurse staff HPRD, 0.55 RN HPRD, and 2.45 NA HPRD minimum staffing requirements, we examined their impact on 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 will need to hire to meet the finalized requirements. 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 will obtain exemptions from these minimum staffing requirements. For the 3.48 total nurse staff HPRD requirement, we continued to subtract any costs that facilities will incur and employees they will need to meet the 24/7 RN requirement since RNs that facilities hire to meet the 24/7 RN requirement will also count toward the 3.48 total nurse staff HPRD requirement. For the 0.55 RN HPRD requirement, we continue to subtract any costs that facilities will incur and employees they will need to hire to meet the 24/7 RN requirements since RNs that facilities hire for the 24/7 RN requirement will also count toward the 0.55 RN HPRD requirement. Finally, for the 2.45 NA HPRD requirement, we continue to subtract any NAs hired to meet the 3.48 total nurse staff requirement since NAs that facilities hire for the 3.48 total nurse staff requirement will also count toward the 2.45 NA HPRD requirement. All calculations used the October 2021 *Care Compare* data set that provided each LTC facility's average daily resident census and average 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 RN hours per resident day. Continuing with our example in this section and assuming the facility did not need to hire any RNs to meet the 24/7 RN requirement, 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 to meet the 3.48

total nurse staff requirement, we subtracted the current average hours per resident day for all nurse staff (RNs, LPNs/LVNs, and 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, 0.187 RN HPRD, and no LPN/LVN HPRD, then to meet the 3.48 HPRD requirement it would need to provide 3,989.5 additional NA hours per year  $[(3.48 \text{ Total Nurse Staff HPRD} - 2.2 \text{ NA HPRD} - .187 \text{ RN HPRD}) \times 10 \text{ residents} \times 365 \text{ days} = 3,989.5 \text{ hours}]$  and hire 2.05 (3,989.5 hours needed/1,950 hours yearly per full-time employee) full-time NAs. This equals an average increase of 1.09 NA HPRD  $(3,989.5/10 \text{ residents}/365 \text{ days} = 1.09 \text{ HPRD})$ . We note, however, that facilities may also wish to use other types of staff such as LPNs/LVNs to meet the total staffing standard.

Finally, to calculate the total number of additional NAs needed to meet the 2.45 NA HPRD requirement, we added together the current average hours per resident day for NAs and the average additional hours per resident day that NAs will work to meet the 3.48 total nurse staff requirement. We then subtracted this new total NA HPRD from the 2.45 NA HPRD minimum required hours per resident day. For example, the

same facility that we discussed above would provide a total of 3.29 NA HPRD  $(2.2 \text{ HPRD from current average NA HPRD} + 1.09 \text{ HPRD from the 3.48 total nurse staff requirement} = 3.29 \text{ NA HPRD})$ . Therefore, it would have already met the 2.45 NA HPRD requirement and would incur no additional costs and would not need to hire any NAs to meet the 2.45 NA HPRD requirement.

Table 25 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 will need to hire to meet each requirement, and the percent increase in RNs and NAs that LTC facilities in each State will need to meet the proposed minimum staffing standards. Table 26 provides the same information for LTC facilities located in each State's rural areas.

Louisiana will need the largest increase in RNs in percentage terms. The number of full-time RNs in urban LTC facilities will need to increase by nearly 96 percent, while rural LTCs will need to increase the number of RNs by more than 73 percent to meet minimum standard. Facilities in Texas will 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 will need to hire varies widely, with several States, including Delaware and Hawaii, not needing to hire any RNs to meet the requirement.

Illinois will need the largest percentage increase for NAs in urban areas to meet the 3.48 total nurse staff requirement. The State will need to add 4,350 full-time NAs and increase the overall number of NAs working in LTC facilities by more than 31 percent. Similar to RNs, however, there is wide variation in the percentage increase in NAs needed for the 3.48 total nurse staff requirement across States. For example, Alaska, North Dakota, the District of Columbia, Delaware, Florida, Hawaii, Idaho, Florida, Maine, and Vermont, will need to increase the size of their NA labor force in urban LTC facilities by less than 1 percent to meet the requirement.

Delaware will need the largest percentage increase for NA in urban areas to meet the 2.45 NA HPRD requirement, increasing the number of NAs by 18.3 percent. For rural areas, Georgia will need the largest percentage increase at 19.5 percent. Across States, however, the number of NAs that facilities will need to hire continues to vary widely.

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**Table 25: Current and Additional Full-Time RNs and NAs Needed per State To Meet 3.48 Total Nurse Staff, 0.55 RN, and 2.45 NA HPRD**

**Staffing Requirements for Urban LTC Facilities**

State	Existing Full-Time RNs	Additional RNs Needed for 0.55 RN HPRD Requirement	% Increase in RNs for 0.55 RN HPRD Requirement	Existing Full-Time CNAs	Additional NAs Needed for 3.48 Total Nurse Staff HPRD Requirement	% Increase in NAs for 3.48 Total Nurse Staff Requirement	Additional NAs Needed for 2.45 NA HPRD Requirement	% Increase in NAs for 2.45 NA HPRD Requirement
Alabama	1,416	129	9.1	5,011	378	7.5	545	10.9
Alaska	108	0	0.0	216	0	0.0	3	1.2
Arizona	1,247	101	8.1	4,036	137	3.4	514	12.7
Arkansas	559	220	39.3	3,775	51	1.3	151	4.0
California	9,461	1,390	14.7	40,659	580	1.4	1,221	3.0
Colorado	2,026	9	0.5	4,687	219	4.7	502	10.7
Connecticut	2,145	122	5.7	6,735	446	6.6	693	10.3
Delaware	648	0	0.0	1,376	7	0.5	252	18.3
District of Columbia	468	0	0.0	923	0	0.0	45	4.9
Florida	8,208	390	4.8	29,310	143	0.5	278	0.9
Georgia	1,469	443	30.1	6,446	921	14.3	1,085	16.8
Hawaii	743	0	0.0	1,289	3	0.2	26	2.0
Idaho	437	1	0.2	1,176	6	0.6	99	8.4
Illinois	5,965	551	9.2	13,944	4,350	31.2	1,852	13.3
Indiana	2,611	261	10.0	8,917	878	9.8	1,226	13.8
Iowa	1,254	28	2.2	4,010	228	5.7	154	3.8
Kansas	1,054	51	4.8	3,652	212	5.8	175	4.8
Kentucky	1,249	100	8.0	3,997	252	6.3	535	13.4
Louisiana	762	730	95.9	6,306	560	8.9	676	10.7
Maine	576	3	0.5	1,499	2	0.2	34	2.3
Maryland	2,939	47	1.6	7,572	346	4.6	1,242	16.4
Massachusetts	3,973	191	4.8	12,156	413	3.4	1,772	14.6
Michigan	3,050	235	7.7	8,862	734	8.3	1,538	17.4
Minnesota	2,968	3	0.1	6,267	187	3.0	404	6.4
Mississippi	509	68	13.3	1,955	103	5.3	219	11.2

State	Existing Full-Time RNs	Additional RNs Needed for 0.55 RN HPRD Requirement	% Increase in RNs for 0.55 RN HPRD Requirement	Existing Full-Time CNAs	Additional NAs Needed for 3.48 Total Nurse Staff Requirement	% Increase in NAs for 3.48 Total Nurse Staff Requirement	Additional NAs Needed for 2.45 NA HPRD Requirement	% Increase in NAs for 2.45 NA HPRD Requirement
Missouri	1,707	442	25.9	7,786	1,314	16.9	353	4.5
Montana	163	4	2.2	487	60	12.3	34	7.0
Nebraska	743	17	2.3	2,313	87	3.8	64	2.8
Nevada	667	45	6.7	1,796	86	4.8	247	13.7
New Hampshire	388	13	3.4	1,256	48	3.8	126	10.1
New Jersey	4,756	335	7.0	13,412	1,087	8.1	1,800	13.4
New Mexico	324	27	8.2	1,184	107	9.1	90	7.6
New York	10,277	745	7.2	32,047	3,406	10.6	2,726	8.5
North Carolina	2,381	376	15.8	9,175	825	9.0	988	10.8
North Dakota	313	1	0.4	1,176	5	0.4	7	0.6
Ohio	5,169	521	10.1	16,844	1,965	11.7	2,628	15.6
Oklahoma	568	203	35.7	3,725	108	2.9	232	6.2
Oregon	762	17	2.3	3,170	5	0.2	9	0.3
Pennsylvania	7,575	242	3.2	20,086	1,669	8.3	3,255	16.2
Puerto Rico	29	0	0.0	0	0	--	26	--
Rhode Island	947	14	1.5	2,752	133	4.8	156	5.7
South Carolina	1,325	163	12.3	4,793	236	4.9	558	11.6
South Dakota	240	0	0.0	618	39	6.2	51	8.3
Tennessee	1,693	230	13.6	6,047	431	7.1	1,068	17.7
Texas	4,451	1,615	36.3	21,663	2,661	12.3	3,460	16.0
Utah	926	2	0.2	2,012	87	4.3	115	5.7
Vermont	72	4	5.0	239	0	0.0	24	10.1
Virginia	1,951	344	17.6	6,838	1,082	15.8	1,082	15.8
Washington	1,967	22	1.1	5,257	47	0.9	264	5.0
West Virginia	682	22	3.2	1,987	117	5.9	313	15.8
Wisconsin	2,214	16	0.7	5,220	257	4.9	363	7.0
Wyoming	85	3	3.4	212	24	11.3	27	12.6
United States	108,220	10,495	9.7	356,871	27,042	7.6	35,306	9.9

**Table 26: Current and Additional Full-Time RNs and NAs Needed per State To Meet 3.48 Total Nurse Staff, 0.55 RN, and 2.45 NA HPRD**

**Staffing Requirements for Rural LTC Facilities**

State	Existing Full-Time RNs	Additional RNs Needed for 0.55 RN HPRD Requirement	% Increase in RNs for 0.55 RN HPRD Requirement	Existing Full-Time CNAs	Additional NAs Needed for 3.48 Total Nurse Staff HPRD Requirement	% Increase in NAs for 3.48 Total Nurse Staff Requirement	Additional NAs Needed for 2.45 NA HPRD Requirement	% Increase in NAs for 2.45 NA HPRD Requirement
Alabama	721	69	9.5	2,884	135	4.7	148	5.1
Alaska	108	0	0.0	256	0	0.0	0	0.0
Arizona	60	4	6.4	169	29	17.1	31	18.2
Arkansas	487	115	23.6	2,930	22	0.8	137	4.7
California	150	37	24.5	847	7	0.8	25	3.0
Colorado	374	6	1.5	1,080	34	3.1	59	5.5
Connecticut	118	6	4.6	379	16	4.3	52	13.8
Delaware	0	0	--	0	0	--	0	--
District of Columbia	0	0	--	0	0	--	0	--
Florida	286	51	17.9	1,501	5	0.4	18	1.2
Georgia	732	177	24.2	3,147	341	10.8	614	19.5
Hawaii	177	0	0.0	393	5	1.3	28	7.2
Idaho	163	1	0.6	542	4	0.8	16	3.0
Illinois	1,049	85	8.1	3,519	688	19.6	308	8.8
Indiana	1,147	51	4.5	3,510	274	7.8	472	13.5
Iowa	1,458	29	2.0	4,789	318	6.6	236	4.9
Kansas	862	10	1.1	3,224	59	1.8	77	2.4
Kentucky	1,212	70	5.8	4,011	191	4.8	358	8.9
Louisiana	262	192	73.4	2,166	65	3.0	218	10.1
Maine	403	0	0.0	1,151	0	0.0	5	0.4
Maryland	125	0	0.0	353	15	4.2	29	8.3
Massachusetts	12	0	0.0	40	0	0.0	0	0.0
Michigan	1,299	19	1.5	3,624	105	2.9	169	4.7
Minnesota	1,218	1	0.1	3,417	14	0.4	99	2.9
Mississippi	982	70	7.1	3,544	108	3.0	408	11.5
Missouri	823	133	16.2	3,959	541	13.7	175	4.4
Montana	356	5	1.5	996	85	8.5	43	4.3
Nebraska	630	13	2.1	2,380	43	1.8	86	3.6
Nevada	61	0	0.0	189	14	7.6	8	4.5
New Hampshire	349	8	2.4	1,206	57	4.7	78	6.5



State	Existing Full-Time RNs	Additional RNs Needed for 0.55 RN HPRD Requirement	% Increase in RNs for 0.55 RN HPRD Requirement	Existing Full-Time CNAs	Additional NAs Needed for 3.48 Total Nurse Staff HPRD Requirement	% Increase in NAs for 3.48 Total Nurse Staff Requirement	Additional NAs Needed for 2.45 NA HPRD Requirement	% Increase in NAs for 2.45 NA HPRD Requirement
New Jersey	0	0	--	0	0	--	0	--
New Mexico	256	7	2.5	796	40	5.0	56	7.0
New York	827	37	4.5	2,609	433	16.6	392	15.0
North Carolina	800	92	11.5	2,945	267	9.1	298	10.1
North Dakota	386	6	1.7	1,331	46	3.4	19	1.4
Ohio	1,681	109	6.5	5,264	580	11.0	824	15.7
Oklahoma	437	94	21.4	3,040	81	2.7	124	4.1
Oregon	158	2	1.1	528	0	0.0	0	0.0
Pennsylvania	1,026	50	4.9	3,152	211	6.7	547	17.3
Puerto Rico	0	0	--	0	0	--	0	--
Rhode Island	0	0	--	0	0	--	0	--
South Carolina	279	62	22.4	1,121	88	7.9	163	14.5
South Dakota	488	2	0.5	1,382	109	7.9	55	4.0
Tennessee	683	78	11.4	2,515	123	4.9	480	19.1
Texas	1,138	311	27.3	6,143	699	11.4	1,067	17.4
Utah	122	0	0.0	269	11	4.2	19	7.1
Vermont	250	2	0.8	734	10	1.4	80	10.9
Virginia	574	99	17.3	1,990	311	15.6	340	17.1
Washington	193	5	2.5	535	37	7.0	46	8.6
West Virginia	399	32	8.0	1,464	86	5.9	137	9.3
Wisconsin	1,142	4	0.3	2,835	155	5.5	187	6.6
Wyoming	245	0	0.0	626	8	1.2	57	9.1
United States	26,708	2,144	8.0	95,485	6,476	6.8	8,787	9.2

We then assessed the financial cost for facilities to implement the 3.48 total nurse staff, 0.55 RN, and 2.45 NA HPRD minimum staffing requirements. 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 each requirement. We also assumed that LTC facilities exceeding the minimum requirements for total nurse staff, RNs and/or NAs will 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 each requirement for all facilities in the State and dividing it by the total number of resident days for all facilities in the state needing to hire staff to meet the requirements. 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 will impose on these facilities.

Table 27 provides the yearly Statewide cost to implement the 3.48 total nurse staff, 2.45 NA, and 0.55 RN HPRD requirements, 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 requirements. Facilities in Illinois that are not meeting the minimum staffing standards will need to spend the most with an average cost of \$21.01 per

resident day. The highest overall cost occurs in New York where facilities will need to collectively spend nearly \$421 million to meet the minimum staffing requirements. The cost also varies across urban and rural areas. In Illinois, LTC facilities in urban areas that need staff will need to spend an average of \$22.34 per resident day to meet the requirement, while in Florida, they will need to spend than \$5.25 per resident day. Virginia had the highest average cost for rural LTC facilities at \$17.65 per resident day.

**Table 27: LTC Facilities in Each State Needing Staff and Average Cost per Resident Day by Rural and Urban Location**

State	Statewide Hiring Cost (\$ Million)	Average Cost per Resident Day (Statewide)	Urban LTC Facilities Needing Staff	Average Cost per Resident Day (Urban Areas)	Rural LTC Facilities Needing Staff	Average Cost per Resident Day (Rural Areas)
Alabama	57.7	\$10.06	120	\$10.60	57	\$8.83
Alaska	0.1	\$7.50	1	\$7.50	0	\$0.00
Arizona	35.8	\$12.07	99	\$12.06	8	\$12.17
Arkansas	34.0	\$7.42	103	\$8.00	80	\$6.58
California	225.6	\$9.68	724	\$9.71	26	\$8.48
Colorado	37.7	\$10.24	122	\$10.32	26	\$9.65
Connecticut	63.5	\$12.07	140	\$12.28	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	54.6	\$5.35	271	\$5.25	22	\$6.48
Georgia	154.5	\$16.30	201	\$17.10	125	\$14.69
Hawaii	2.7	\$9.61	5	\$8.38	3	\$10.84
Idaho	5.3	\$6.95	29	\$7.38	11	\$5.32
Illinois	364.0	\$21.01	412	\$22.34	155	\$14.94
Indiana	151.2	\$14.05	307	\$14.77	151	\$12.15
Iowa	42.4	\$9.27	97	\$9.52	174	\$9.10
Kansas	25.9	\$9.40	89	\$10.72	58	\$6.55
Kentucky	67.7	\$11.11	111	\$13.22	110	\$8.73
Louisiana	118.2	\$15.60	175	\$16.76	70	\$12.10
Maine	2.4	\$5.89	12	\$7.17	4	\$2.02
Maryland	77.5	\$12.02	167	\$12.15	10	\$8.64
Massachusetts	125.5	\$12.59	306	\$12.59	0	\$0.00
Michigan	128.9	\$14.82	250	\$15.80	68	\$9.55
Minnesota	34.4	\$10.33	109	\$11.13	49	\$7.58
Mississippi	38.4	\$9.49	54	\$10.95	103	\$8.62
Missouri	125.4	\$13.68	233	\$15.15	144	\$10.48
Montana	10.8	\$14.31	13	\$15.02	27	\$13.80
Nebraska	13.4	\$8.81	26	\$10.39	58	\$7.63
Nevada	18.5	\$14.06	34	\$13.96	4	\$15.92
New Hampshire	19.1	\$14.06	27	\$13.38	19	\$15.04
New Jersey	164.7	\$14.87	285	\$14.87	0	\$0.00
New Mexico	15.6	\$11.02	29	\$11.47	22	\$10.04
New York	421.0	\$15.09	430	\$15.03	72	\$15.65

State	Statewide Hiring Cost (\$ Million)	Average Cost per Resident Day (Statewide)	Urban LTC Facilities Needing Staff	Average Cost per Resident Day (Urban Areas)	Rural LTC Facilities Needing Staff	Average Cost per Resident Day (Rural Areas)
North Carolina	128.3	\$13.15	256	\$13.50	87	\$12.03
North Dakota	4.5	\$12.40	5	\$7.81	15	\$13.98
Ohio	289.7	\$14.79	577	\$15.30	227	\$13.16
Oklahoma	41.1	\$9.26	108	\$10.70	96	\$7.17
Oregon	2.8	\$4.91	26	\$4.76	1	\$8.28
Pennsylvania	298.2	\$14.98	470	\$15.21	101	\$13.56
Puerto Rico	0.0	\$0.0	3	\$0.0	0	\$0.0
Rhode Island	16.3	\$9.99	53	\$9.99	0	\$0.00
South Carolina	59.4	\$12.63	113	\$12.40	35	\$13.41
South Dakota	11.2	\$10.15	21	\$10.03	44	\$10.22
Tennessee	101.9	\$13.12	181	\$13.71	100	\$11.77
Texas	408.7	\$15.40	773	\$15.96	303	\$13.47
Utah	7.6	\$6.50	49	\$6.50	8	\$6.52
Vermont	6.3	\$10.75	4	\$12.28	16	\$10.28
Virginia	156.8	\$19.30	179	\$19.81	63	\$17.65
Washington	23.4	\$10.28	78	\$9.40	15	\$15.54
West Virginia	30.1	\$10.88	59	\$11.00	44	\$10.68
Wisconsin	41.3	\$11.26	114	\$11.82	75	\$10.31
Wyoming	6.2	\$13.06	6	\$14.37	13	\$12.02
United States	4,284.2	\$13.83	8,096	\$13.86	2,911	\$11.59

Table 28 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 nurse will be \$1.84, while in Illinois, the average cost per resident day for facilities with more than 100 beds will be \$22.78.

**Table 28: Number of LTC Facilities in Each State Needing to Hire Nursing Staff and Average Cost per Resident Day by Facility Size**

State	LTC Facilities Needing Staff	Statewide Hiring Cost (\$ Million)	Average Cost per Resident Day (Statewide)	Cost — <50 Beds	Cost — 50 to 100 Beds	Cost — >100 Beds
Alabama	177	57.7	\$10.06	\$5.60	\$8.70	\$10.52
Alaska	1	0.1	\$7.50	\$0.00	\$7.50	\$0.00
Arizona	107	35.8	\$12.07	\$11.89	\$7.44	\$13.24
Arkansas	183	34.0	\$7.42	\$0.00	\$7.42	\$7.42
California	750	225.6	\$9.68	\$5.33	\$9.23	\$10.25
Colorado	148	37.7	\$10.24	\$10.94	\$9.34	\$10.76
Connecticut	152	63.5	\$12.07	\$19.07	\$10.35	\$12.38
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	54.6	\$5.35	\$7.69	\$5.79	\$5.25
Georgia	326	154.5	\$16.30	\$10.12	\$14.78	\$17.23
Hawaii	8	2.7	\$9.61	\$8.73	\$14.83	\$8.42
Idaho	40	5.3	\$6.95	\$5.52	\$7.80	\$6.43
Illinois	567	364.0	\$21.01	\$8.86	\$14.86	\$22.78
Indiana	458	151.2	\$14.05	\$14.24	\$12.93	\$14.85
Iowa	271	42.4	\$9.27	\$8.91	\$9.09	\$10.15
Kansas	147	25.9	\$9.40	\$8.70	\$8.67	\$11.26
Kentucky	221	67.7	\$11.11	\$9.16	\$11.13	\$11.16
Louisiana	245	118.2	\$15.60	\$4.91	\$10.11	\$16.54
Maine	16	2.4	\$5.89	\$0.00	\$6.38	\$4.78
Maryland	177	77.5	\$12.02	\$6.97	\$9.83	\$12.44
Massachusetts	306	125.5	\$12.59	\$11.71	\$11.40	\$12.84
Michigan	318	128.9	\$14.82	\$12.36	\$12.54	\$16.00
Minnesota	158	34.4	\$10.33	\$10.30	\$10.33	\$10.34
Mississippi	157	38.4	\$9.49	\$12.76	\$7.99	\$10.45
Missouri	377	125.4	\$13.68	\$6.62	\$10.08	\$15.68
Montana	40	10.8	\$14.31	\$16.03	\$17.84	\$10.77

State	LTC Facilities Needing Staff	Statewide Hiring Cost (\$ Million)	Average Cost per Resident Day (Statewide)	Cost — <50 Beds	Cost — 50 to 100 Beds	Cost — >100 Beds
Nebraska	84	13.4	\$8.81	\$8.13	\$7.39	\$11.48
Nevada	38	18.5	\$14.06	\$6.79	\$9.47	\$15.33
New Hampshire	46	19.1	\$14.06	\$4.31	\$13.58	\$14.62
New Jersey	285	164.7	\$14.87	\$10.34	\$11.22	\$15.13
New Mexico	51	15.6	\$11.02	\$10.24	\$11.04	\$11.03
New York	502	421.0	\$15.09	\$9.47	\$17.42	\$14.95
North Carolina	343	128.3	\$13.15	\$11.27	\$11.72	\$13.99
North Dakota	20	4.5	\$12.40	\$9.93	\$5.47	\$19.27
Ohio	804	289.7	\$14.79	\$11.28	\$13.80	\$16.37
Oklahoma	204	41.1	\$9.26	\$1.84	\$5.59	\$11.21
Oregon	27	2.8	\$4.91	\$8.68	\$3.79	\$5.94
Pennsylvania	571	298.2	\$14.98	\$12.93	\$12.77	\$15.46
Puerto Rico	3	--	--	--	--	--
Rhode Island	53	16.3	\$9.99	\$10.23	\$9.29	\$10.29
South Carolina	148	59.4	\$12.63	\$8.79	\$12.50	\$12.82
South Dakota	65	11.2	\$10.15	\$9.37	\$9.79	\$13.07
Tennessee	281	101.9	\$13.12	\$7.40	\$11.86	\$13.69
Texas	1076	408.7	\$15.40	\$10.03	\$12.80	\$16.41
Utah	57	7.6	\$6.50	\$9.95	\$6.88	\$5.73
Vermont	20	6.3	\$10.75	\$5.46	\$15.05	\$9.59
Virginia	242	156.8	\$19.30	\$6.73	\$16.15	\$20.36
Washington	93	23.4	\$10.28	\$10.68	\$8.44	\$11.48
West Virginia	103	30.1	\$10.88	\$9.03	\$9.86	\$11.90
Wisconsin	189	41.3	\$11.26	\$7.93	\$10.52	\$12.56
Wyoming	19	6.2	\$13.06	\$0.00	\$8.37	\$14.84
United States	11,010	4,284.2	\$13.83	\$9.68	\$14.36	\$11.42

In table 29, we calculated the average cost by State for facilities needing staff to meet the minimum staffing requirements based on whether the facility accepted patients with Medicare, Medicaid, or both Medicare

and Medicaid. The highest per resident day cost will be for 14 Medicaid-only facilities in North Dakota that will need to spend an average of \$42.48 per resident day to meet the staffing requirements. The lowest per resident

day cost for facilities needing staff will be for two Medicare-only facilities in West Virginia that will need to spend \$0.59 per resident day to meet the requirements.

**Table 29: Number of LTC Facilities in State Needing to Hire Staff and the 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	\$10.09
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	\$7.53
California	7	\$3.51	19	\$28.85	721	\$9.09
Colorado	9	\$5.85	3	\$28.34	135	\$10.19
Connecticut	0	\$0.00	0	\$0.00	151	\$12.05
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	\$5.34
Georgia	4	\$5.94	0	\$0.00	322	\$16.40
Hawaii	0	\$0.00	0	\$0.00	8	\$9.61
Idaho	0	\$0.00	0	\$0.00	40	\$6.95
Illinois	9	\$5.58	14	\$42.48	542	\$20.62
Indiana	7	\$17.82	5	\$11.21	444	\$14.06
Iowa	2	\$3.09	5	\$11.49	261	\$9.28
Kansas	1	\$12.98	9	\$22.98	136	\$8.82
Kentucky	5	\$9.72	0	\$0.00	214	\$11.13
Louisiana	6	\$4.27	0	\$0.00	232	\$15.34
Maine	0	\$0.00	0	\$0.00	16	\$5.89
Maryland	2	\$10.02	0	\$0.00	174	\$12.06
Massachusetts	4	\$14.14	0	\$0.00	296	\$12.59
Michigan	1	\$6.28	1	\$2.71	314	\$14.75
Minnesota	4	\$5.84	6	\$32.60	146	\$9.20
Mississippi	3	\$19.62	12	\$9.74	142	\$9.41
Missouri	5	\$9.63	6	\$17.31	365	\$13.68
Montana	0	\$0.00	0	\$0.00	40	\$14.31
Nebraska	0	\$0.00	3	\$7.53	77	\$8.86
Nevada	3	\$6.74	1	\$26.14	34	\$13.79
New Hampshire	0	\$0.00	1	\$6.60	45	\$14.27
New Jersey	5	\$8.83	0	\$0.00	278	\$14.71
New Mexico	0	\$0.00	1	\$8.08	50	\$11.04
New York	0	\$0.00	0	\$0.00	500	\$15.12
North Carolina	7	\$11.76	1	\$17.82	332	\$13.17
North Dakota	1	\$31.33	0	\$0.00	18	\$12.66
Ohio	5	\$8.84	0	\$0.00	792	\$14.81
Oklahoma	2	\$6.39	2	\$6.92	200	\$9.31
Oregon	0	\$0.00	2	\$7.52	23	\$4.60
Pennsylvania	33	\$9.70	1	\$3.98	535	\$15.15
Puerto Rico	3	\$0.00	0	\$0.00	0	\$0.00
Rhode Island	0	\$0.00	0	\$0.00	53	\$9.99
South Carolina	10	\$6.87	0	\$0.00	137	\$12.82
South Dakota	0	\$0.00	6	\$7.01	58	\$10.46
Tennessee	18	\$9.05	4	\$8.30	259	\$13.36

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
Texas	23	\$8.53	6	\$10.40	1,039	\$15.56
Utah	4	\$9.15	4	\$13.36	49	\$6.09
Vermont	0	\$0.00	0	\$0.00	20	\$10.75
Virginia	9	\$3.26	5	\$15.09	226	\$19.68
Washington	0	\$0.00	0	\$0.00	93	\$10.28
West Virginia	2	\$0.59	1	\$8.01	98	\$10.81
Wisconsin	2	\$1.40	1	\$5.13	184	\$11.35
Wyoming	0	\$0.00	0	\$0.00	19	\$13.06
United States	222	\$8.04	124	\$21.13	10,585	\$13.38

**BILLING CODE 4120-01-C****b. Benefits of LTC Minimum Staff Requirement**

Evidence in the literature suggests that higher staffing is associated with better quality of patient care and patient health outcomes.<sup>118 119 120</sup> 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. An example of such evidence 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.<sup>121</sup> 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 finalized 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 with the finalization of these requirements, 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. The 2022 Study then used Nurse Home Compare Data from 2021 Q2 to 2022 Q1 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. The study 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, the study assumed that facilities would maintain their current RN staffing level. Based on the facility's number of short-stay residents, as well as long-stay resident days, the study then estimated the total savings at the facility level. To measure costs savings for Medicare, the study 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.<sup>122</sup>

Given that our final 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 Nursing Home Staffing Study did not quantify them. Additionally, while the savings estimate above reflects an acuity-adjusted standard, given variability in acuity across facilities, we believe that these savings estimates

<sup>118</sup> 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.

<sup>119</sup> 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/10.1177/07464819843045> <https://doi.org/10.1177/07464819843045>

<sup>120</sup> 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 U.S. Nursing Home Compare database. *Geriatric Nursing*, 40(2), 160–165. <https://doi.org/10.1016/j.g>

<sup>121</sup> In the study, appendix E, section E.1.1 provides details on the criteria used for the acuity adjustment.

<sup>122</sup> 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>.



provide guidance on the impact of applying the minimum staffing requirements independent of a facility’s case-mix.

Table 30 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.

**Table 30: 0.55 RN 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
<b>Total 10 Year Savings</b>	<b>\$2,546,077,720</b>

We expect that the 24/7 RN, 3.48 total nurse staff, and 2.45 NA HPRD requirements will also bring substantial benefits for residents, staff and LTC facilities. As we noted in the statement of need for this regulatory impact analysis, there is a positive association between the number of hours of care that a resident receives each day and resident health and safety.<sup>123 124 125</sup> The higher staffing standards we are finalizing and the resultant improvements in quality and safety will also provide greater assurance to residents’ families—an important, but difficult to quantify, measure.

Research also suggests that there is a positive relationship between inadequate staffing and nursing staff burnout, which can lead to high employee turnover, and conversely,

higher nurse staffing levels is associated with lower nurse staff turnover rates, suggesting that higher staffing levels will benefit employees by providing a better work environment.<sup>126 127</sup> LTC facilities are likely to benefit from the higher staffing levels in the long-term with a reduction in the number of new staff they will need to hire and train, and lowered dependence on temporary workers, who often command higher hourly wages.

Lower turnover rates will also benefit residents and LTC facility operators. Higher turnover rates are associated with a variety of problems in LTC facilities including lower quality of resident care, worse performance on claims-based quality measures, a greater likelihood of LTC facilities receiving an infection control deficiency citation, and more overall survey deficiency citations, while higher long-term licensed nurse (RN and LPN) retention rates are correlated with lower 30-day rehospitalization rates and higher nursing assistant (NA) retention rates are associated with fewer overall deficiency citations, quality of care deficiency citations, and deficiencies

that pose an immediate jeopardy to resident health or safety.<sup>128 129 130 131 132 133 134</sup>

Sources of uncertainty about the benefits of the 24/7 RN, 3.48 total nurse staff, 0.55 RN, and 2.45 NA HPRD requirements 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,

<sup>123</sup> 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/>.

<sup>124</sup> 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/>.

<sup>125</sup> Min A., Hong, H.C., Effect of nurse staffing on rehospitalizations and emergency department visits among short-stay nursing home residents: A Cross-sectional study using the U.S. 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.

<sup>126</sup> Kelly, L.A., Gee, P.M., Butler, R.J. 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.

<sup>127</sup> Donoghue, C. (2010). Nursing Home Staff Turnover and Retention: An Analysis of National Level Data. *Journal of Applied Gerontology*, 29(1), 89–106. <https://doi.org/10.1177/0733464809334899>.

<sup>128</sup> Harrington, C., Swan, J.H. Nursing home staffing, turnover, and case mix. *Med. Care Res. Rev.* 2003;60(3):366–92; discussion 393–9. DOI: 10.1177/1077558703254692.

<sup>129</sup> Castle, N.G., Engberg, J. Staff Turnover and Quality of Care in Nursing Homes. *Medical Care* 2005;43(6):616–626.

<sup>130</sup> Zheng, Q., Williams, C.S., Shulman, E.T., White, A.J. 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.

<sup>131</sup> Loomer, L., Grabowski, D.C., Yu, H., Gandhi, A. Association between nursing home staff turnover and infection control citations. *Health Serv. Res.* 2022;57(2):322–332. DOI: 10.1111/1475-6773.13877.

<sup>132</sup> Lerner, N.B., Johantgen, M., Trinkoff, A.M., Storr, C.L., Han, K. Are nursing home survey deficiencies higher in facilities with greater staff turnover. *J. Am. Med. Dir. Assoc.* 2014;15(2):102–7. DOI: 10.1016/j.jamda.2013.09.003.

<sup>133</sup> Thomas, K.S., Mor, V., Tyler, D.A., Hyer, K. The relationships among licensed nurse turnover, retention, and rehospitalization of nursing home residents. *Gerontologist* 2013;53(2):211–21. DOI: 10.1093/geront/gns082.

<sup>134</sup> Castle, N.G., Hyer, K., Harris, J.A., Engberg, J. Nurse Aide Retention in Nursing Homes. *Gerontologist* 2020;60(5):885–895. DOI: 10.1093/geront/gnz168.

take into account how changes in the number of hours per resident day of other direct care or support staff that occur in response to the finalized requirements 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.<sup>135 136</sup> If LTC facilities respond to the 24/7 RN, 3.48 total nurse staff HPRD, the 0.55 RN HPRD, and the 2.45 NA HPRD 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, 3.48 total nurse staff, 0.55 RN HPRD, and 2.45 NA HPRD requirements would maintain RN, NA, and total 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.<sup>137</sup> If LTC facilities reduced RN, NA, and total nurse 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 no real growth in the financial value of reduced Emergency Department visits and hospitalizations, as well as increase in discharges to home or the community. If, however, the cost of Emergency Department visits and hospitalizations grows faster than the rate of inflation, then value of these benefits will be higher than what we have estimated here.

The benefit estimates assumed that the nursing home resident population

will remain stable over the next 10 years. There is some evidence, however, that the resident population is declining. CMS *Care Compare* data shows that between February 2017 and February 2024, the average number of residents in nursing homes per day declined from 1,346,712 residents to 1,207,726.<sup>138</sup> If the resident population continues to decrease, then the benefits could be lower than what we have estimated. Similarly, if the pattern changes and the nursing home resident population increases, the benefits could be higher than what we have estimated.

The benefits estimate assumed that no LTC facilities would obtain exemptions from the 24/7 RN, 3.48 total nurse staff HPRD, 0.55 RN HPRD, and 2.45 NA HPRD requirements, although some facilities could obtain such an exemption. Based only on being located in an area with a nurse staffing shortage, a preliminary analysis of the data suggests that more than 29 percent of facilities would be eligible for an 8-hour exemption from the 24/7 RN requirement and the 0.55 RN HPRD requirement, 23 percent of facilities would be eligible for an exemption from the 2.45 NA HPRD requirement, and 22 percent of facilities would be eligible for an exemption from the 3.48 HPRD total nurse staff requirement. Since facilities would also need to meet all other requirements to obtain an exemption, however, these numbers are not reflective of the number of facilities estimated to fully qualify for the exemptions as they only describe the number of facilities that would satisfy the workforce availability criterion. 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.

d. 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, 3.48 total nurse staff HPRD, 0.55 RN HPRD, and the 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.

(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 delivery systems, we are finalizing new reporting requirements at § 442.43(b) and (c) for States to report annually by facility on the percent of payments for Medicaid-covered services delivered by nursing facilities and ICFs/ IID that are spent on compensation for direct care workers and support staff.

As finalized, States are required to report annually to CMSs 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 finalizing that States are required to post all reported data on a State-maintained website (or link to such information on an MCO's or PIHP's website, as applicable), which States must ensure is reviewed quarterly to verify the accurate function of the website and that 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

The following discussion is based on costs to States, the Federal Government, and providers that were summarized in table 24 and described in detail in the Collection of Information (section V. of this final rule). As outlined in section V., we estimate one-time implementation costs of \$838,475 for States to come into compliance with the reporting requirements finalized at § 442.43(b) and (c). As discussed in section V., the Federal Government, through Federal Financial Participation,

<sup>135</sup> 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.

<sup>136</sup> 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.

<sup>137</sup> Chen, Min M., and David C. Grabowski. Intended and Unintended Consequences of Minimum Staffing Standards for Nursing Homes, 2015, Volume 24, Pages 822–839.

<sup>138</sup> CMS. (2024). Nursing homes including rehab services archived data snapshots. Accessed March 19, 2024. Available at: <https://data.cms.gov/provider-data/archived-data/nursing-homes>.

has a share in Medicaid expenditures, which for the purposes of these burden estimates is 50 percent of Medicaid expenditures. Thus, we estimate the one-time costs of the reporting requirement finalized at § 442.43(b) and (c) as \$419,237 for States and \$419,237 for the Federal Government. We estimate an annual total cost of \$97,470 once the reporting requirement goes into effect; again, as the costs will be split between States and the Federal Government, we estimate the annual ongoing costs as \$48,735 for States and \$48,735 for the Federal Government. A breakdown of these figures may be found in tables 18 and 19 in the Collection of Information (section V. of this final rule.)

Additionally, under finalized § 442.43(d), States are required to make this information available on a public website; as outlined in the Collection of Information (section V. of this rule), we estimate a one-time implementation costs of \$239,333 for States to come into compliance with this requirement; as the costs will be split between States and the Federal Government, we estimate the one-time cost for States as \$119,667 and \$119,667 for the Federal Government. We estimate an ongoing annual cost of \$295,527 once reporting starts; as the costs will be split between States and the Federal Government, we estimate the one-time cost as \$147,764 for States and \$147,764 for the Federal Government. A breakdown of these figures may be found in tables 22 and 23 in section V.

The total State and Federal costs for both the reporting and website requirements are thus estimated at \$1,077,808 for implementation costs (\$838,475 + \$239,333) and \$392,997 ongoing annual costs once the reporting starts (\$97,470 + \$295,527).

As discussed in the Collection of Information (section V. of this rule), we estimate that the total cost to providers to prepare for compliance with the reporting requirement finalized at § 442.43(b) and (c) will be \$36,560,002, and an annual total cost to providers of \$17,912,717. A breakdown of these figures may be found in tables 30 and 31 in section V.

We do not estimate a cost to providers for the website posting requirement finalized at § 442.43(d). We also do not anticipate costs to beneficiaries associated with these requirements.

Table 31 provides a detailed summary of the estimated costs of each of the requirements for States, the Federal Government, and providers. Table 32 summarizes the estimated costs of the requirements 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 the finalized changes to part 442, subpart B. The implementation costs associated with the finalized reporting and website posting requirements are split evenly over the

years leading up to the finalized effective date, which is 4 years from this 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 to 10 in table 32. 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 (inflation-indexed) dollars.

As discussed in the Collection of Information (section V. of this 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 a managed care delivery system; 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 31: 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	419,237	419,237	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	119,667	- -	239,333	- -
Website – Recurring annual starting Year 5	147,763	147,763	-	- -	295,526
<b>Total</b>	<b>735,402</b>	<b>735,402</b>	<b>54,472,719</b>	<b>- 37,637,809</b>	<b>18,305,713</b>

**Table 32: Projected Distribution of Costs for Proposed Updates to 42 CFR Part 442, Subpart B**

Year	State Costs	Federal Costs	Provider Costs	Total Costs associated with § 442.43
1	183,851	183,851	9,140,000	9,507,702
2	183,851	183,851	9,140,000	9,507,702
3	183,851	183,851	9,140,000	9,507,702
4	183,851	183,851	9,140,000	9,507,702
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	1,914,392	1,914,392	144,036,302	147,865,086

**b. Benefits of Medicaid Institutional Payment Transparency Reporting**

Our finalized requirements are intended to support the sufficiency of the direct care and support staff workforce through public reporting of compensation to these workers. While we believe this finalized provision will provide benefits, we are not able to quantify these benefits at this time.

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 finalized requirements 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 finalized provisions.

**D. Alternative Direct Care Staff HPRD Requirement Considered**

As detailed earlier in this final 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 are finalizing are consistent with current standards of practice and necessary to increase

resident safety and quality of care. We acknowledge, however, that there were multiple avenues for establishing a minimum nurse staffing requirement and in the proposed rule we solicited comments on alternative policy options, including a specific comment solicitation in the "Provisions of the Proposed Regulation" section.

In developing the final rule, we considered varying staffing models that were 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 staffing requirement such as separate requirements for RNs, LVNs/LPNs, and NAs or creating standards for NAs only. We could also have implemented individual HPRD requirements for RNs and NAs together with a 24/7 RN requirement but excluded any requirement for an overall nurse staffing HPRD level, which was a policy discussed in detail in the proposed rule. 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 have also focused on the need to increase or decrease the number of HPRD or FTEs by nurse staff and/or type or on specifying the number of staff by shift (including day, evening, night, or weekends or over a 24-hour period).

Ultimately, we chose the comprehensive 24/7 RN, 3.48 total nurse staff HPRD, 0.55 RN HPRD, and 2.45 NA HPRD requirements in this final 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 RN 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 compared to baseline RN HPRD levels that are in the two lowest deciles for nursing homes nationwide would lead to a large decline in quality of care. For example, the 2022 Nursing Home Staffing Study<sup>139</sup> 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 also considered alternative minimum staffing requirements at the same level we are finalizing but with a longer phase-in period for the 3.48 total nurse staff HPRD requirement. We ultimately decide to provide a shorter phase-in period for the 3.48 total nurse staff HPRD requirement to ensure resident health and safety.

**2. Medicaid Institutional Payment Transparency Reporting**

We considered, but did not finalize, a proposal to require States to report per diem FFS rate for nursing facility and ICF/IID services; we did not finalize this proposal as we believed it would duplicate other reporting requirements.

We also considered, but did not finalize, a proposal to require States to report on median hourly wage and to require that States report data by job title. We did not finalize this proposal 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.

*E. Regulatory Review Costs*

1. Regulatory Review Costs of 24/7 RN, 3.48 Total Nurse Staff, 0.55 RN and 2.45 NA HPRD Minimum Nurse Staffing Requirements

If the 24/7 RN and the Minimum Nurse staffing requirements impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. As discussed in the Collection of Information (section V. of this final rule), 14,688 LTC facilities will be impacted by the finalized requirements. We assume that all 14,688 LTC facilities will proactively review this final rule. (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 the costs of reviewing this rule. It is possible 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 also recognize that different types of entities are in many cases affected by

mutually exclusive sections of some final 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 3.48 total nurse staff, 0.55 RN, and 2.45 NA HPRD requirements.

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](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 final rule pertains to the 24/7 RN, 3.48 total nurse staff HPRD, 0.55 RN HPRD, and 2.45 NA HPRD requirements, 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 final rule pertaining to the 24/7 RN and the 3.48 total nurse staff HPRD, 0.55 RN HPRD, 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 \$2,403,985 (\$163.67 × 14,688).

2. Regulatory Review Costs of Medicaid Institutional Payment Transparency Reporting

As discussed in the Collection of Information (section IV. of the proposed rule at 88 FR 61393 and 61395), 54 State Medicaid agencies and approximately 19,907 nursing facilities and ICFs/IID would be impacted by the requirements, totaling 19,961 interested parties. We

note that there was an error in the proposed rule at 88 FR 64124 that stated incorrectly that 52, rather than 54 State Medicaid agencies were affected by the rule; we have corrected that figure here.

As discussed in the proposed rule at 88 FR 64124, we estimated that 75 percent of these affected entities would proactively review the final rule. We welcomed any comments on this approach but did not receive any comments. Therefore, we are calculating the regulatory review burden associated with the provision finalized at § 442.43 using this assumption. We estimate that 14,971 entities read the rule for the purpose of reviewing the provision finalized at § 442.43 [(54 + 19,907) × 75 percent.]

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](https://www.bls.gov/oes/current/oes_nat.htm), for medical and health service managers (Code 11–9111), we estimated 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 estimated 10,000 words were read by reviewers), we estimated that it would take 40 minutes or 0.67 hours for the staff to review portions of the sections of the final rule pertaining to the Medicaid Institutional Payment Transparency Reporting. For each employee that reviewed the rule, the estimated cost is \$82.45 (0.67 hours × \$123.06). Therefore, we estimated that the total one-time cost of reviewing this regulation is \$1,234,359 (\$82.45 × 14,971).

Table 33 provides the total estimated regulatory review costs for the rule, which is \$3,638,344.

**Table 33: Regulatory Review Cost**

Medicaid Institutional Payment Transparency Reporting	24/7 RN, 3.48 Total Nurse Staff and 0.55 RN and 2.45 NA HPRD Minimum Nurse Staffing Requirements	Total Cost
\$1,234,359	\$2,403,985	\$3,638,344

*F. Accounting Statement*

As required by OMB Circular A–4 (available online at [https://obama.whitehouse.archives.gov/omb/circulars\\_a004\\_a-4/](https://obama.whitehouse.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 final rule. This includes the total cost for the 24/7 RN and the 3.48 total nurse staff HPRD, 0.55 RN HPRD, and 2.45 NA HPRD requirements as

provided in table 22, the total cost for the Medicaid Institutional Transparency Reporting as provided in table 18, the total cost for the regulatory review as provided in table 33, and Medicare savings due to fewer hospitalizations

and emergency department visits, as well as greater return to home and community, as provided in table 30.

There are \$0 in transfer estimates in the statement. This statement provides our

best estimate for the Medicare and Medicaid provisions of this rule.

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**Table 34: Accounting Statement: 24/7 RN Requirement, 3.48 Total Nurse Staff, 0.55 RN, and 2.45 NA HPRD Requirements, and Medicaid Institutional Payment Transparency Reporting Requirement**

Category	Estimates	Units		
		Year Dollar	Discount Rate	Period Covered
<b>Benefits</b>				
Annualized Monetized (\$million/year)	236	2021	7%	2024-2033
	247	2021	3%	2024-2033
<b>Costs</b>				
Annualized Monetized (\$million/year)	3,999	2021	7%	2024-2033
	4,179	2021	3%	2024-2033

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*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 \$9.0 million to \$47.0 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 entities impacted are considered small businesses according to the Small Business Administration’s size standards with total revenues of \$47 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.

Adjusting this amount for inflation, as measured by the Consumer Price Index, combined revenues in 2021 Dollars are approximately \$179.5 billion. Overall, the cost is estimated to be between 2.23 and 2.32 percent of revenues.

**Table 35: Regulatory Flexibility Act Analysis**

	<b>Annual Revenue</b>	<b>Estimated Average Annual Cost for Providers with 3% Discount Rate</b>	<b>Estimated Average Annual Cost for Providers with 7% Discount Rate</b>	<b>Cost as % of Revenue with 3% Discount Rate</b>	<b>Cost as % of Revenue with 7% Discount Rate</b>
Skilled Nursing Facilities and Intellectual and Developmental Disabilities Facilities	\$179,582,997,397	\$3,999,000,000	\$4,179,000,000	2.23	2.32

This rule will not have a significant impact as measured by a 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 final rule. Therefore, the Secretary has certified that this final 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 604 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 provisions 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 \$183 million. Based on the cost estimates discussed in this section, we have assessed the various costs and benefits of the final updates to the requirements for participation for LTC facilities. These final 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 final 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 final

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 total nurse staff, 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 we are requiring in this final 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 final 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 finalized in this rule or from meeting higher staffing levels required based on the facility assessment provisions finalized in this rule.

In accordance with the provisions of Executive Order 12866, this final 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 April 10, 2024.

### 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 amends 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 facility services and services delivered in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).* The State must comply with the requirements in § 442.43 for nursing facility and ICF/IID services.

(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 is revised to read as follows:

**Authority:** 42 U.S.C. 1302.

■ 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, life and disability insurance, paid leave, retirement, 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 direct support professional;

(vii) A personal care aide;

(viii) A medication assistant, aide, or technician;

(ix) A feeding assistant;

(x) Activities staff; or

(xi) Any other individual who is paid to provide clinical services, behavioral supports, active treatment (as defined at § 483.440 of this chapter) or address activities of daily living (such as those described in § 483.24(b) of this chapter) for Medicaid-eligible individuals receiving Medicaid services under this part, including nurses and other staff providing clinical supervision.

(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;

(vi) A security guard; or

(vii) 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.

(4) *Excluded costs* means costs reasonably associated with delivering Medicaid-covered nursing facility or ICF/IID services that are not included in the calculation of the percentage of Medicaid payments to providers that is spent on compensation for direct care workers and support staff. Such costs are limited to:

(i) Costs of required trainings for direct care workers and support staff (such as costs for qualified trainers and training materials);

(ii) Travel costs for direct care workers and support staff (such as mileage reimbursement or public transportation subsidies); and

(iii) Costs of personal protective equipment for facility staff.

(b) *Reporting requirements.* The State must report to CMS annually, by facility, the percentage of Medicaid payments (not including excluded costs) 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. For the purposes of this part, Medicaid payment for fee-for-service (FFS) includes base and supplemental payments as defined in section 1903(bb)(2) of the Social Security Act, and for payments from a managed care organization (MCO) or prepaid inpatient health plan (PIHP) (as these entities are defined in § 438.2 of this chapter) includes the MCO's or PIHP'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 MCO or PIHP.

(1) *Services.* Except as provided in paragraphs (b)(2) and (3) 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.



(3) *Exclusion of data from the Indian Health Service and Tribal health programs.* States must exclude data from the Indian Health Service and Tribal health programs subject to the requirements at 25 U.S.C. 1641 from the reporting required in paragraph (b) of this section.

(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 a 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 MCO or PIHP contracts, the State may meet this requirement by linking to individual MCO's or PIHP's 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) *Applicability date.* States must comply with the requirements in this section beginning 4 years after June 21, 2024; and in the case of the State that implements a managed care delivery

system under the authority of section 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and includes nursing facility services or ICF/IID services, the first rating period for contracts with the MCO or PIHP beginning on or after 4 years after June 21, 2024.

**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. Section 483.5 is amended 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.

\* \* \* \* \*

■ 7. Section 483.10 is amended by revising paragraph (h)(3)(i) to read as follows:

**§ 483.10 Resident rights.**

\* \* \* \* \*

- (h) \* \* \*
- (3) \* \* \*

(i) The resident has the right to refuse the release of personal and medical records except as provided at § 483.70(h)(2) or other applicable Federal or State laws.

\* \* \* \* \*

■ 8. Section 483.15 is amended by revising paragraph (c)(8) to read as follows:

**§ 483.15 Admission, transfer, and discharge rights.**

\* \* \* \* \*

- (c) \* \* \*

(8) *Notice in advance of facility closure.* In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care

Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).

\* \* \* \* \*

■ 9. Section 483.35 is revised to read as follows:

**§ 483.35 Nursing services.**

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.71.

(a) *Sufficient staff.* (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

- (i) Except when waived under paragraph (f) of this section, licensed nurses; and
- (ii) Other nursing personnel, including but not limited to nurse aides.

(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(4) Providing care includes but is not limited to assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs.

(b) *Total nurse staffing (licensed nurses and nurse aides).* (1) The facility must meet or exceed a minimum of 3.48 hours per resident day for total nurse staffing including but not limited to—

- (i) A minimum of 0.55 hours per resident day for registered nurses; and
- (ii) A minimum of 2.45 hours per resident day for nurse aides.

(2) One or more of the hours per resident day requirements at paragraph (b)(1) of this section may be exempted for facilities found non-compliant and who meet the eligibility criteria defined at paragraph (h) of this section as determined by the Secretary.

(3) Compliance with minimum total nurse staffing hours per resident day as

set forth in one or more of the hours per resident day requirements of paragraph (b)(1) of this section should not be construed as approval for a facility to staff only to these numerical standards. Facilities must ensure there are a sufficient 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 at § 483.71.

(c) *Registered nurse.* (1) Except when waived or exempted under paragraph (f), (g), or (h) of this section, the facility must have a registered nurse (RN) onsite 24 hours per day, for 7 days a week that is available to provide direct resident care.

(2) For any periods when the onsite RN requirements in paragraph (c)(1) of this section are exempted under paragraph (h) of this section, facilities must have a registered nurse, nurse practitioner, physician assistant, or physician available to respond immediately to telephone calls from the facility.

(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(d) *Proficiency of nurse aides.* The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(e) *Requirements for facility hiring and use of nursing aides—*(1) *General rule.* A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless—

(i) That individual is competent to provide nursing and nursing related services; and

(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§ 483.151 through 483.154; or

(B) That individual has been deemed or determined competent as provided in § 483.150(a) and (b).

(2) *Non-permanent employees.* A facility must not use on a temporary, per

diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(1)(i) and (ii) of this section.

(3) *Minimum competency.* A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—

(i) Is a full-time employee in a State-approved training and competency evaluation program;

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program; or

(iii) Has been deemed or determined competent as provided in § 483.150(a) and (b).

(4) *Registry verification.* Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—

(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or

(ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(5) *Multi-State registry verification.* Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under section 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.

(6) *Required retraining.* If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program.

(7) *Regular in-service education.* The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of § 483.95(g).

(f) *Nursing facilities: Waiver of requirement to provide licensed nurses*

*and a registered nurse on a 24-hour basis.* To the extent that a facility is unable to meet the requirements of paragraphs (a)(1), (b)(1)(i), and (c)(1) of this section, a State may waive such requirements with respect to the facility if—

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in this paragraph (f) is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their resident representatives of the waiver.

(g) *SNFs: Waiver of the requirement to provide services of a registered nurse for at least 112 hours a week.* (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (c) of this section, if the Secretary finds that—

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) The facility either—

(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of

a registered nurse or a physician for a 48-hour period; or

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders; and

(v) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (g)(1) of this section is subject to annual renewal by the Secretary.

(h) *Hardship exemptions from the minimum hours per resident day and registered nurse onsite 24 hours per day, for 7 days a week requirements.* A facility may be exempted by the Secretary from one or more of the requirements of paragraphs (b)(1) and (c)(1) 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 and receive a hardship exemption:

(1) *Location.* The facility is located in an area where the supply of applicable healthcare staff (RN, nurse aide (NA), or total nurse staffing, as indicated in paragraphs (h)(1)(i), (ii), and/or (iii) of this section) is not sufficient to meet area needs as evidenced by a provider to population ratio for nursing workforce that is a minimum of 20 percent below the national average, as calculated by CMS, by using data from the Bureau of Labor Statistics and Census Bureau.

(i) The facility may receive an exemption from the total nurse staffing requirement of 3.48 hours per resident day at paragraph (b)(1) of this section if the combined licensed nurse, which includes both RNs and licensed vocational nurses (LVN)/licensed practical nurses (LPNs) and nurse aide to population ratio in its area is a minimum of 20 percent below the national average.

(ii) The facility may receive an exemption from the 0.55 registered nurse hours per resident day requirement at paragraph (b)(1)(i) of this section and an exemption of 8 hours a day from the registered nurse on site 24

hours per day, for 7 days a week requirement at paragraph (c)(1) of this section if the registered nurse to population ratio in its area is a minimum of 20 percent below the national average.

(iii) The facility may receive an exemption from the 2.45 nurse aide hours per resident day requirement at paragraph (b)(1)(ii) of this section if the nurse aide to population ratio in its area is a minimum of 20 percent below the national average.

(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); 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) *Disclosure of exemption status.* The facility:

(i) Posts, in a prominent location in the facility, and in a form and manner accessible and understandable to residents, and resident representatives, a notice of the facility's exemption status, the extent to which the facility does not meet the minimum staffing requirements, and the timeframe during which the exemption applies; and

(ii) Provides to each resident or resident representative, and to each prospective resident or resident representative, a notice of the facility's exemption status, including the extent to which the facility does not meet the staffing requirements, the timeframe during which the exemption applies, and a statement reminding residents of their rights to contact advocacy and oversight entities, as provided in the

notice provided to them under § 483.10(g)(4); and

(iii) Sends a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(5) *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).

(6) *Determination of eligibility.* The Secretary, through CMS or the State, will determine eligibility for an exemption based on the criteria in paragraphs (h)(1) through (5) of this section. The facility must provide supporting documentation when requested.

(7) *Timeframe.* The term for a hardship exemption is from grant of exemption until the next standard recertification survey, unless the facility becomes a Special Focus Facility, is cited for widespread insufficient staffing with resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm, or is cited at the immediate jeopardy level of severity with respect to insufficient staffing as determined by CMS, or fails to submit Payroll Based Journal data in accordance with § 483.70(p). A hardship exemption may be extended on each standard recertification survey, after the initial period, if the facility continues to meet the exemption criteria in paragraphs (h)(1) through (5) of this section, as determined by the Secretary.

(i) *Nurse staffing information—(1) Data requirements.* The facility must post the following information on a daily basis:

(i) Facility name.  
(ii) The current date.  
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.  
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).  
(C) Certified nurse aides.  
(iv) Resident census.

(2) *Posting requirements.* (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents, staff, and visitors.

(3) *Public access to posted nurse staffing data.* The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) *Facility data retention requirements.* The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

■ 10. Section 483.40 is amended by revising paragraphs (a) introductory text, (a)(1), and (c)(2) to read as follows:

**§ 483.40 Behavioral health services.**

\* \* \* \* \*

(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with § 483.71. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to § 483.71; and

\* \* \* \* \*

(c) \* \* \*

(2) Obtain the required services from an outside resource (in accordance with § 483.70(f)) from a Medicare and/or Medicaid provider of specialized rehabilitative services.

\* \* \* \* \*

■ 11. Section 483.45 is amended by revising the introductory text to read as follows:

**§ 483.45 Pharmacy services.**

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an

agreement described in § 483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

\* \* \* \* \*

■ 12. Section 483.55 is amended by revising paragraphs (a) introductory text, (a)(1), (b) introductory text, and (b)(1) introductory text to read as follows:

**§ 483.55 Dental services.**

\* \* \* \* \*

(a) *Skilled nursing facilities.* A facility:

(1) Must provide or obtain from an outside resource, in accordance with § 483.70(f), routine and emergency dental services to meet the needs of each resident;

\* \* \* \* \*

(b) *Nursing facilities.* The facility:

(1) Must provide or obtain from an outside resource, in accordance with § 483.70(f), the following dental services to meet the needs of each resident:

\* \* \* \* \*

■ 13. Section 483.60 is amended by revising paragraph (a) introductory text to read as follows:

**§ 483.60 Food and nutrition services.**

\* \* \* \* \*

(a) *Staffing.* The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.71. This includes:

\* \* \* \* \*

■ 14. Section 483.65 is amended by revising paragraph (a)(2) to read as follows:

**§ 483.65 Specialized rehabilitative services.**

(a) \* \* \*

(2) In accordance with § 483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any Federal or State health care programs pursuant to section 1128 and 1156 of the Act.

\* \* \* \* \*

**§ 483.70 [Amended]**

■ 15. Section 483.70 is amended by—  
 ■ a. Removing paragraph (e); and

■ b. Redesignating paragraphs (f) through (g) as paragraphs (e) through (p), respectively.

■ 16. Add § 483.71 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 needs, 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;

(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).

(b) In conducting the facility assessment, the facility must ensure:

(1) Active involvement of the following participants in the process:

(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and

(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.

(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

(2) [Reserved]

(c) 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.

■ 17. Section 483.75 is amended by revising paragraphs (c)(2) and (e)(3) to read as follows:

**§ 483.75 Quality assurance and performance improvement.**

\* \* \* \* \*

(c) \* \* \*

(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at § 483.71 and including how such information will be used to develop and monitor performance indicators.

\* \* \* \* \*

(e) \* \* \*

(3) As a part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at § 483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection

and analysis described in paragraphs (c) and (d) of this section.

\* \* \* \* \*

■ 18. Section 483.80 is amended by revising paragraph (a)(1) to read as follows:

**§ 483.80 Infection control.**

\* \* \* \* \*

(a) \* \* \*

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to § 483.71 and following accepted national standards.

\* \* \* \* \*

■ 19. Section 483.95 is amended by revising the introductory text to read as follows:

**§ 483.95 Training requirements.**

A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to—

\* \* \* \* \*

**Xavier Becerra,**  
*Secretary, Department of Health and Human Services.*