Centers for Medicare & Medicaid Services
National Nursing Home Stakeholder Call
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Jean Moody-Williams: Good afternoon. We still have a few people, joining us, but I think we should go ahead and get started. Thank you so much for joining today. It's been a little while since we've had the opportunity to get together, but we want to make sure we're making good use of your time when we call these meetings. I am Jean Moody-Williams, the Deputy Center Director of the Center for Clinical Standards and Quality at CMS.

Before we get into the content, I would like to share a few housekeeping items before we get started. The webinar is being recorded, and it will be posted on the CMS national stakeholders call webpage and we'll be sure to drop that link so that you can have that for the recording for those who may not have had the opportunity to join us on such short notice. All participants will be muted throughout the call. And closed captioning is available via the link in the closed caption window on the bottom of the screen. Members of the press may be on the call today. However, all press and media questions should be submitted using the CMS Media Inquiries form, and that can be found at https://www.cms.gov/newsroom/media-inquiries. And I think if you're on this call you probably already have that link.

We always have a full agenda when we call you all together and today is no exception. I am joined by several of my colleagues from CMS. The general focus of today's call is to provide an overview of the newly released final rule to establish minimum nursing staffing requirements with the nursing homes, which really is meant to drive the delivery of safe quality care for the residents, and we'll discuss the Medicaid institutional payment transparency reporting final rule as well. So we'll talk about both of those portions of the rule.

To get us started, I'm going to turn the call over to Dr. Dora Hughes who is the acting Chief Medical Officer and the acting Director of the Center for Clinical Standards and Quality.

Dora Hughes: Thank you, Jean, and good afternoon, everyone. On Monday, in conjunction with the Care Week of Action, as many of you may know, CMS issued a historical final rule to establish minimum nurse staffing requirements within nursing homes to drive the delivery of safe quality care for all residents. This final rule is a cornerstone to President Biden's action plan for nursing home reform. CMS is unwavering in its commitment to improve safety and quality of care. For the over 1.2 million residents receiving care in Medicare and Medicaid certified nursing homes adequate staffing is critical to ensuring that nursing homes provide an environment where residents receive safe high quality care. It is the measure most closely linked to the quality of

care residents receive. However, despite existing requirements that nursing homes provide sufficient levels of staffing, persistent under staffing remains.

CMS received over 46,000 public comments on this proposed role. As a part of the public comment period, we receive many stories that shared instances of residents waiting and hoping for someone to help in their time of need. Many going hours without toileting assistance or days without showers, having medication passes delayed or missed entirely, and experiencing preventable safety events such as falls and pressure ulcers. Many family members within their comments also recounted efforts to help stretched and exhausted nursing staff and care team provide basic support to their loved ones. We also received many comments from labor unions and labor organizations with ideas and feedback on ways to strengthen the rule and how we should enforce the minimum nurse staffing requirements, including by ensuring that direct care staff, the nurses who are intimately familiar with the unique needs of their residents, have a voice in identifying staff and resource needs to deliver safe quality care.

This final rule which was informed by public comment and the totality of available evidence represents a critical step in addressing this important issue by holding nursing homes accountable for providing adequate staffing, thereby creating a long-term care system where residents can safely age with dignity. On a personal note, throughout the rulemaking process, I've been fortunate enough to join various conversations about long-term care staffing in general and the requirements in place. During this time, I've listened to you. I've learned from you directly and through the comments that many of you submitted. We're hoping for continued partnership and input as we move forward with implementing this rule.

And now I'm going to turn the mic over to Adam who can dive deeper into the rule and share more information. Thank you.

Adam Richards: Great, well thank you Dr. Hughes and good afternoon everyone. And I want to thank you all for spending some time with us today to hear about this important final rule and the requirements moving forward. I think we have some slides if we could show those. Great. Thank you. So can we go to the next slide please. Perfect. Thank you. So as Dr. Hughes mentioned, we received over 46,000 public comments in response to our proposed rule. We considered all public comments to help inform our final approach and based on the comments as well as the totality of available evidence we are finalizing the nurse staffing requirements at this time to address the persistent understaffing that continues to exist within long term care facilities, and to take a significant step toward improving quality and safety for residents. So on the next slide.

As a bit of a refresher, the staffing portion of this rule contains 3 core requirements: first, we have the minimum nurse staffing standards or the hours per resident day (HPRD). We also have the registered nurse onsite, 24/7 requirements. And we have our enhanced facility assessment requirements. So let's start with the minimum staffing standards on the next slide, please.

So, as you all may recall, we proposed individual standards of .55 HPRD for registered nurses and 2.45 HPRD for nurse aids. We also saw comments on an alternative 3.48 HPRD total nurse

staffing standard. Based on the comments we are finalizing a 3.48 HPRD total nurse staffing standard, inclusive of individual requirements of .55 HPRD for registered nurses and 2.45 HPRD for nurse aids. We believe that the 3.48 HPRD total nurse staffing standard addresses many concerns we saw as a part of the public comments. Particularly in that it establishes a total that provides for more hours of direct care to residents to further reduce the risk of unsafe and low-quality care, as well as allowing facilities to utilize licensed practical nurses or LPNs. This total nurse staffing standard provides facilities with the flexibility to choose nursing staff including LPNs and LVNs that are already on staff or maybe even newly hired to meet the remaining .48 HPRD to achieve compliance. So if we move on to the next slide.

We propose to require that long-term care facilities have a registered nurse onsite, 24 hours per day, 7 days per week. We are finalizing this requirement as proposed. So long-term care facilities will be required to have a registered nurse on site, 24 hours a day, 7 days a week. And we received many comments acknowledging the importance of having registered nurses available in long-term care facilities to either prevent or quickly triage emergent issues that are beyond the scope of LPNs or nurse aides, particularly for residents with medically complex and acute health conditions. Having a registered nurse on site 24 hours a day, 7 days a week also helps to mitigate against potential preventable safety events particularly during nights, weekends, and holidays. Importantly, we are also finalizing an exemption of 8 hours for the 24/7 registered nurse requirements that I'll discuss momentarily when we get to the exemption framework.

So on the next slide, in terms of the facility assessment. We are finalizing this requirement as proposed as well. We appreciate all of the supportive comments on the continued use of the facility assessment as a foundational approach to identifying the resources needed to safely and effectively care for residents. So in this final rule, we are requiring that facilities must use evidence-based methods when care planning for their residents. And facilities must use the facility assessment to assess the specific needs for each resident unit in the facility. And then on the next slide. We are also requiring that facilities include the inputs of facilities staff, which includes, but it's not limited to nursing home leadership, managements, direct care staff, so nurse staff, representatives of employees and staff as well as staff who provide other services to residents. And then finally, we are also requiring that facilities consider the specific staffing needs, for each shift and to adjust as necessary based on any changes to the resident population.

So those are the core staffing specific requirements that comprise this final rule. So just to recap, facilities will be required to meet a total nurse staffing standard of 3.48 hours per resident day and that is inclusive of .55 hours per resident day for registered nurses and 2.45 hours per resident day for nurse aids. They must also have a registered nurse onsite, 24 hours a day, 7 days a week. And they must meet the updated facility assessment requirements. So now if we move on to the next slide.

I want to spend a little bit of time discussing the hardship exemption framework. Again, while we believe the staffing requirements are necessary and achievable, we propose to provide time limited exemptions from the minimum staffing standards, so the hours per resident day, to eligible long-term care facilities that may be facing workforce challenges. We received many comments on the exemption framework, both in support and opposition, as well as advancing

practical recommendations on how to streamline any potential process to provide flexibility to long-term care facilities that are truly facing hardships. As such, we are finalizing the exemption framework to provide temporary relief from the minimum nurse staffing standards and 8 hours of the 24/7 RN requirement. We have also made several modifications based on public comments. So, let's discuss what that framework will look like now. Starting on the next slide, please.

So first, in order to qualify for an exemption, we are finalizing that a long-term care facility must be in a workforce shortage area where the provider to population ratio is 20% below the national average. This is the only requirement to qualify for an exemption. And just to explain the provider to population ratio a little more, this is a per capita calculation to determine if there sufficient nursing workforce in a specific geographic area. So just using an example, if the national registered nurse average is one registered nurse to 108 people, then the 20% threshold would be one registered nurse to 130 people. So now on the next slide, in order to receive the exemption, we are finalizing that a long-term care facility must document a good faith effort to hire as well as the annual amount spent on staff. We are also finalizing 2 additional transparency criteria based on public comments. So, in addition to documenting a good faith effort and annual staff spending, a long-term care facility must post their exemption status within the facility. And must also provide residents, prospective residents, and the state ombudsman with an individual notice of the exemption status, including the degree to which they do not meet the staffing requirements. So, moving on to the next slide.

As I mentioned earlier, we are finalizing that the hardship exemption can apply to both the minimum staffing requirements, the hours per resident day, as well as the 24/7 onsite registered nurse requirement. So, a facility located in a registered nurse workforce shortage area, which is determined by the provider to population ratio, can receive an exemption of 8 hours from the 24/7 registered nurse requirement. For any periods when the onsite 24/7 registered nurse requirements are exempted facilities must have either a registered nurse, a nurse practitioner, a physician assistant, or even a physician available to respond immediately to telephone calls from the facility. Importantly, I would also note that the existing statutory waivers specific to the on-site registered nurse remain. Our final exemption framework complements those waivers and provides flexibility for long-term care facilities that may not qualify for a statutory waiver.

So just to give you a practical sense of what this looks like, we have a couple of examples on screen. So, for example, a facility may receive an exception from the total nurse staffing requirements of 3.48 HPRD if the combined licensed nurse (registered nurses and LPNs) and nurse aid to population ratio in its area is a minimum of 20% below the national average. The facility may receive an exception from the .55 registered nurse HPRD requirements and an exception of 8 hours a day from the 24/7 RN requirements if the RN to population ratio in its area is a minimum of 20% below the national average, and the same is true for nurse aids. The facility may receive an exemption from the 2.45 HPRD requirement if the nurse aid to population ratio in in the geographic area is a minimum of 20% below the national average. So, if we move on to the next slide, please.

The key point that I'll mention here is that we are finalizing our approach to surveying a facility prior to receiving an exemption. Then if we determine that a facility is in a workforce shortage

area, the facility could qualify for and receive the exemption after fulfilling the documentation and transparency requirements that I just discussed.

On the next slide, and this is really the last thing that I'll mention on the exemption framework is that we are also finalizing several exceptions as proposed that would make facilities ineligible to receive an exemption. So, these include failing to submit data to the payroll-based journal system, being identified as a special focus facility, or being identified within the preceding 12 months as having widespread pattern of insufficient staffing that has resulted in actual harm, or an incident of insufficient staffing that caused or is likely to cause serious harm or death to a death to a resident.

On the next slide, the last piece of the staffing specific part of this rule that I'll cover is the implementation time frame. Again, while we believe that long-term care facilities can meet these staffing requirements, we recognize the unique challenges that facilities may face, particularly in rural areas. As such, we propose a staggered implementation timeframe based on geographic location where non-rural facilities would need to meet the staffing requirements within 3 years of the effective date of the final rule and rural facilities would need to meet the requirements within 5 years. So based on public comments, we are finalizing the implementation timeframe as proposed. While also adding the total nurse staffing standard to the timeline. This is responsive to the concerns commenters raised about workforce challenges and giving facilities more time to conduct staff assessments to continue working to bring on and train staff and to allow training programs to begin.

So, the implementation will occur in phases. So, non-rural facilities will need to meet the facility assessment requirements 90 days after the effective date of the final rule. They would need to meet the 24/7 registered nurse and total nurse staffing hours per resident day 2 years after the effective date of the final rule. And they would need to meet the individual registered nurse and nurse aid hours per resident day 3 years after the effective date of the final rule.

On the next slide, this represents the phases for rural facilities. So, similar to non-rural facilities, these facilities will need to meet the facility assessment requirement 90 days after the effective date of the final rule. Rural facilities will need to meet the 24/7 RN and total nurse staffing hours per resident day 3 years after the effective date of the final rule, and they would need to meet the individual registered nurse and nurse aid hours per resident day 5 years after the effective date of the final rule. So, moving on to the last slide.

Overall, we strongly believe that this is a balanced final rule that reflects the available evidence and public comments, and it is responsive to potential workforce concerns, particularly in rural areas. And most importantly, it protects residents from unsafe, low-quality care while also improving the care that residents receive on a daily basis. And with that, I'm going to turn it back to you, Jean. Thank you all.

Jean Moody-Williams: Thank you, Adam, for walking through that. As I move I want to take a look at some of the questions in the Q&A. I'm going to come back to that after we move through

some more of the content. But I have been reviewing the comments related to the workforce challenges. We, as I mentioned, will address the, questions shortly, but, we did consider that in, finalizing this rule in addition to the made implementation dates and the exemptions. And statutory waivers. We're also launching a, staffing campaign. And September of 2023, we actually announced that the agency would be investing over 75 million to launch a national nursing home staffing campaign really designed to increase the number of nurses in the nursing home and enhancing the residents safety and health care.

Here are just a few details of the program. Through this campaign we will be providing financial incentives for nurses to work in the nursing home. For example, nurses could receive tuition reimbursement by fulfilling a commitment to work in a qualifying nursing home. We will also be making it easier for individuals to become their saves by streamlining the process for enrolling and training programs and finding placements in nursing homes. For example, we'll be working with states to improve the functionality of their training website. We'll make it easier for people to find the locations of state approved nurse a training program.

We'll be using the campaign to promote an awareness of the many career pathways in nursing fields that are available. For example, one pathway could be how nurse A could progress to be an LPN and then an RN or someone maybe that is an RN can progress to become a director of nursing in a nursing home or supervisor, in that work area. So that's some of the things we'll be highlighting. And to accomplish this task, we'll launch an awareness campaign that highlight these components, the educational approach and there'll be key messages to kind of motivate, them to take action and highlighting positive aspects of working in nursing homes.

It's fulfilling work and we've done some work to try and recruit surveyors and others and we want to try this campaign, to get nursing home professionals and nurse aides and others, to improve perspective. We will also have a web page. It is served as a hub for information on the campaign and where individuals can follow the path that's going to be most appropriate for them. And we're partnering with states, which I think is important to bolster nurse recruitment in their states. For example, states will be able to invest their funds and kind of combine their funds with us to improve nurse a training websites and increase the number of financial incentives that are available for registered nurses in their state.

So, we're right now, we're conducting comprehensive research to help inform the structure of the program and we look forward to releasing additional information later this year. We'll get the word out to you so you can get the word out as well. So the financial incentives will be distributed in 2025. Now, this is not apart of the staffing regulation, I just want to put that out, that this is not a partnered rule. But we did want to bring this to your attention, particularly given some of the comments in the Q&A. So before we go to adjusting, I'd like to turn the call over to, Jen Bolden and Blackfield to address the Medicaid portion of the rule.

Anne Blackfield: Thank you, Jean. My name is Anne Blackfield and I will be providing an overview of the Medicaid institutional payment transparency reporting requirement. This requirement which was included in the overall minimum staffing role, required states to report annually at the facility level on the percent of Medicaid payments for nursing facilities services and intermediate care facilities for individuals with intellectual disabilities, that is spent on compensation for direct care workers and support staff. Examples of direct care workers are

nurses and therapy staff. Support staff includes housekeepers and workers providing transportation to residents.

I will quickly review what we are finalizing, including changes we made after receiving public comment on the NPRM. So what didn't change? The broad outline of the rule is as proposed. State reports on the percent of Medicaid payments going to compensation for drug care workers and support staff. The supplies only to payments were medicated the primary payer. Reporting will be for nursing facilities and intermediate care facilities for individuals with intellectual disabilities. But will exclude swing bed payments.

Both states and CMS will report this data on our websites. And reporting will begin in 4 years as we proposed. So, what changed? States will report data for both services delivered under fee per service and managed care, which is what we proposed. But one difference from the NPRM is that states will not be required to report this data separately.

The definition of drug care workers was amended to include nurses and other staff who provide clinical supervision. It was also amended to include direct support professionals. The definition of support staff was amended to include security guards. We are allowing facilities to exclude certain costs associated with travel, training, and PPE from the calculation. This means that when facilities are calculating the percent of their Medicaid payments that is going to compensate, some costs for travel, training and PPE will be deducted from the Medicaid payment before the calculation of performed.

Although we are not requiring a facilities spend a certain percent at their Medicaid payments on compensation. We heard concerns from both providers and direct care workers that travel, training, and PPE aren't really compensation for workers, but they also aren't really administrator over overhead costs either. We wanted to make sure that providers still felt encouraged to invest in these activities and items and not be worried that these expenses are accounting against what they are spending on compensation. That's why we finalized that these would be excluded from the calculation. We are also exempting the Indian health service and certain tribal health programs subject to 25 USC section 1641 from the reporting requirements. And this is to avoid conflict with certain statutory requirements regarding how these providers allocate their Medicaid dollars currently.

And then just to note that this requirement also aligns with a similar reporting requirement that was finalized in the ensuring access to Medicaid services final rule which displayed on Monday as well. That rule also requires that states report on the percent of Medicaid payments for certain home and community-based services that is spent on compensation direct care workers. However, In the ensuring access rule, we are also requiring that states ensure that these providers spend a minimum percent of their Medicaid payments on compensation with certain exceptions. As I noted earlier, we did not finalize a similar minimum threshold producing facilities and ICFIDs in this role. So, this is again a reporting requirement. And so that covers, those sets of requirements that I will turn it back to Jean.

Thanks.

Jean Moody-Williams: Thanks so much for, covering that and, now we're going to go to a few, answer a few of the questions and answers. I'll state that the slides will be made available that's

got we received that question several times and that this session will be posted it is being recorded. So, you'll be able to get that information.

It was also question about assisted living facilities. To be clear, this role is not applicable to assisted living facilities. And Adam, maybe we'll go to this question. There's a little confusion. How is the, 24/7 are in requirement different from the minimum staffing standard?

Adam Richards: Yeah, thanks, Jean. That's a that's a great question. And so, think about it this way. The minimum staffing standards identify the average number of hours of care that residents in a long-term care facility must receive per day. From either a registered nurse, a nurse aide or other nurse staff. Such as LPNs. So, these numbers are typically expressed as hours per present day or HPR deal as we've been discussing throughout today's presentation. The finalized, 24/7 registered nurses. Requirements established that establishes that a registered nurse. Must be on site at a facility, 24 hours a day, 7 days a week and is available to provide direct resident care anytime during the day, evening, nights, weekends, holidays, you name it.

Jean Moody-Williams: Thank you for that. There's also a lot of discussion about our definition, what is a nurse aid? What are we considering to be a nurse aid?

Adam Richards: Yeah, great question. I know we; a lot of folks ask that question too during our proposed role making. So we currently define the term nurse aid as certified nurse aids, AIDS and training, and medication aids or medication technicians. So, this term may also include an individual who provides these services. Through an agency or under contract with the facility but is not a licensed health professional a registered dietician or someone who volunteers to provide such services without pay. Nurse aids also do not include those individuals who furnish services to residents only as paid feeding assistance either.

Jean Moody-Williams: Okay, great. And let me also say that we keep a copy of all the questions and answers. I know we won't get to them all today, but we keep a copy and we'll either schedule additional sessions or we'll be getting guidance, and we certainly will be getting guidance out. So if we aren't getting to your question be sure that we are recording it and will look to get additional information out as necessary. So you talked about exemptions. How will a facility apply for an exemption?

Adam Richards: Yeah, again, that's a great question. We get this question a lot. So, to be clear, long-term care facilities do not need to apply for an exception. So, prior to being granted an exception, the long-term care facility must be surveyed to assess the health and safety of residents. If a facility is found non-compliant with the minimum staffing requirements while not meeting the exclusionary criteria that we discussed earlier, then the long-term care facilities documentation of a good faith effort to hire and retain staff. And their documentation of financial commitment to adequate staffing must be submitted to either the states or to CMS. So once that

documentation is submitted and the transparency requirements that I touched on earlier meant a facility can be granted an exception.

Jean Moody-Williams: So, the other point, there are several questions about exemptions. I know we can't get to them all, but how long does an exemption last and why can't we just do a simple blanket exemption?

Adam Richards: Yeah, so the hardship exemption last, or their time limit. Let me start by saying that the hardship exemptions are time limited. So, following the initial survey to determine eligibility a facility will be re-evaluated at every recertification as to whether it is eligible for a renewal of a hardship exception. Of course, we strongly encourage facilities to conduct a facility assessment and to work expeditiously to meet the minimum staffing requirements. And I know we've gotten a lot of questions around, you know, why is a survey necessary before granting an exception?

Let me say this. If a facility is found non-compliant with the minimum staffing requirements. The intent of a survey by CMS is to ensure that there are not a larger, more serious quality of care issues that are stemming from insufficient staffing before granting an exemption. We want to ensure that residents are safe and receiving quality care before providing an exemption. And this type of safeguard is not something we can necessarily do through an application process or if through a blanket exception.

Jean Moody-Williams: Thanks, Adam. I saw a couple of questions about the facility assessment and let me just say that the facility assessment is very important because these are minimum staffing requirements, and it is fully expected that some facilities will require more than the minimum. And we know that states also have requirements as well. And we, would expect that the facility assessment will guide your staffing decisions as you make those decisions. It's very important, for that. We will be getting out additional guidance, as, we, move on. I know there's a request for template on how to do the facility assessment. So just to let you know that additional information will be coming out as we work with our quality safety and oversight group and our Quality Oversight Survey Group on that matter. So, yes.

Adam Richards: In Jean, I'm sorry if I could just piggyback because I think you make a really great point. I saw this a couple of times in the chat as I was able to quickly look through it. Just remember with these minimum staff and requirements what we are doing we are finalizing is a federal floor that can be broadly, so all long-term care facilities promote safe and high-quality care. So, facilities must meet those minimum standards, but we also expect facilities to staff above those minimums based on, as Jean just mentioned, the facility assessments and determining overall resident acuity and to be able to meet your residence care needs.

Jean Moody-Williams: Yeah, absolutely. Thanks, Adam. So, I want to give you 2 more questions before. I know our time is short. Does CMS anticipate modifying and finalizing the minimum staffing thresholds in the future.

Adam Richards: So CMS plans to conduct ongoing monitoring and evaluation of the staffing requirements within this final rule. As they are implemented over the next several years. Should subsequent data indicate that additional revisions to the staffing requirements or definitions or the exception framework are warranted. We will revisit these standards and update the regulations.

Jean Moody-Williams: Okay, great. Okay, last question and we've stated this a couple of times, but I think it just bears repeating, given the number of questions on this. Did CMS considered the ability of facilities across the country to hire sufficient staff? And how can nursing homes meet these requirements if there's a work shortage?

Adam Richards: Yeah, it's a great question. It's a great comment. We did see this a number of times within the, over 46,000 public comments that we received, and We did consider the ability for facilities to meet the minimum staffing requirements, which we do believe are achievable. We recognize that there are unique challenges at some long-term care facilities, which were both highlighted and exacerbated by the COVID-19 public health emergency. Our focus with this rule is on advancing implementable solutions that promote safe and high-quality care for residents while considering the current challenges that some facilities may be facing. With that consideration as we've discussed today, we have finalized a staggered implementation of the final provisions for facilities based on geographic location to provide a runway toward compliance.

As well as temporary exemptions for facilities that are facing a true hardship despite their best efforts to hire nursing staff. And Jean, there is one more question that if you'll allow me, I want to address this quickly because I've seen this go a few times as well. We have a lot of questions right now on how are we defining world for the purposes of this rule. I will just say that we are defining rural in this rule, using the OMB, the Office of Management Budget Definition, which essentially states that all counties that are not part of a metropolitan management budget definition, which essentially states that all counties that are not part of a metropolitan statistical area are considered rural. So all counties that have 50,000 or more people, are, would not be considered. So, anything under 50,000 would be considered rural.

Jean Moody-Williams: Okay, and I'm going to add one more question. I've seen this a couple of times. Why are we? Not counting LPNs. Can you address that?

Adam Richards: So we are. We are providing the flexibility for long-term care facilities to count LPMs based on the evidence that we've had during the proposed rulemaking cycle as well

as some of what we saw come through during the public comment period. We have identified that both registered nurses and nurse aides have a demonstrated effect on quality. So, we are finalizing those individual standards. But we have moved to a total nurse staffing standard that will allow long-term care, the long-term care facilities, the flexibility to count LPN toward that total standard.

Jean Moody-Williams: Thank you, thank you. I didn't want us to end without that being clear that that is that will in fact count. So, again, I know that, thanks to the, CMS team, they've been answering some of the questions as we go along. The slides will be available. So we will post those along with the recording. I want to thank you again for joining us and thank you as we always do for all you do. As we all approach this very, critical need, CMS can never do this alone. And we never say that we can. So, we'll all work together to address these important issues. Thank you and have a great day.