LeadingAge Testimony for the Record
House Energy and Commerce Subcommittee on Health Hearing
"Supporting Access to Long-Term Services and Supports: An Examination of the Impacts of Proposed Regulations on Workforce and Access to Care."
October 25, 2023

Chairs Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and distinguished members of the House Energy and Commerce Subcommittee on Health, we thank you for holding this important hearing to examine the current state of the nursing and caregiving workforce and the impacts of the proposed rules on Minimum Staffing Levels for Long-Term Care Facilities (CMS-3442-P) and Ensuring Access to Medicaid Services (CMS-2442-P). If implemented, both rules could have serious unintended and deleterious consequences on how care is delivered across the entire country. We commend you for recognizing that long-term care should not be siloed and for focusing on the continuum of long-term care services in this hearing. What affects one setting or service will have ripple effects across the entire health and long-term care system. The policies that HHS is proposing will ultimately limit access to essential care and harm older people and their families.

LeadingAge represents more than 5,000 non-profit aging services providers, and other mission-minded aging services organizations. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Program for All Inclusive Care for the Elderly, and Medicare and Medicaid funded home care.

The US Healthcare system is navigating a new and unfamiliar landscape in the wake of the COVID-19 Public Health Emergency (PHE). Three years of sustained stress and increasing workloads have caused a dramatic shift in staffing patterns and an alarming rise in burnout across health and long-term care professions. Although shortages had emerged prior to the pandemic, they have reached a crisis point in its wake. According to the *United States Registered Nurse Workforce Report Card and Shortage Forecast of 2019*, a shortage of registered nurses is projected to spread across the country through 2030. While 30 states are likely to experience a shortage, those in the Western, and more rural, regions of the US will likely experience acute nursing shortages.[1]

The Proposed Federal Staffing Standard on Nursing Homes
The mission driven members of LeadingAge fought valiantly throughout the COVID-19 public health emergency to protect the most vulnerable, older Americans, while acting as critical partners in their local health delivery systems. Our members' efforts to care for those after in-patient treatment for COVID-19 prevented acute care hospitals from reaching capacity and ensured doctors and nurses were able to continue to provide lifesaving care. However, as the long-term care community emerges from a deadly pandemic and seeks to find the "new normal" we are met with a renewed push for unrealistic staffing mandates. According to the federal Bureau of Labor Statistics, the nursing home and other care facilities' workforce

[1] Juraschek, S. P., Zhang, X., Ranganathan, V. K., & Lin, V. W. (2019b). Republished: United States Registered Nurse Workforce Report Card and Shortage forecast. *American Journal of Medical Quality*, *34*(5), 473–481. https://doi.org/10.1177/1062860619873217

shrunk by 410,000 workers nationally between March 2020 and November 2021. While it began to rebound in February 2022, these nursing homes and other residential care facilities still have more than a 200,000-person deficit in their workforce. At the same time, the 65+ population grows by more than 10,000 individuals per day. The ultimate trajectory if we don't address the long-term care health care workforce shortage is more working adults will need to leave the broader workforce to care for their loved ones at home. This isn't just a health care problem.

Nursing homes that serve and employ your constituents are facing the possibility of closing because they will not be able to comply with the government's proposed federal minimum staffing standard. LeadingAge shares the Administration's goal of ensuring access to the highest quality care in our nation's 15,000 nursing homes. However, the proposed rule works against this shared goal and puts residents at risk by failing to address the chronic reimbursement challenges and workforce shortages plaguing the long-term care continuum.

Specific concerns with the federal minimum staffing standard include but are not limited to:

- **There is no funding to hire and retain the 90,000 new staff CMS estimates will be needed.** CMS estimates the cost of meeting the proposed rule's staffing levels is $40.6 billion over 10 years with an average annual cost of $4.06 billion. Independent estimates paint a starker picture and indicate a larger financial investment is required. According to a report by CLA (CliftonLarsonAllen LLP) estimates the cost at $6.8 billion per year, and the analysis performed by LeadingAge places it at $7.1 billion per year. (*Please see enclosed LeadingAge Analysis of Additional Yearly Costs and FTEs to Meet Proposed Staffing Regulation 2023.*) The costs of delivering quality care already far exceed Medicaid reimbursement levels[2], and this unrealistic mandate will force nursing homes to consider limiting admissions or even closing their doors for good, depriving vulnerable older and disabled of care.

- **There simply aren't enough people to hire.** As is true for most retail, food service, and hospitality businesses, a mandate will not solve the long-standing workforce shortages impacting nursing homes and the rest of long-term care continuum, particularly in rural and underserved areas. A 2020 study by the University of Washington found that the supply of primary care providers per capita is lower in rural areas compared to urban areas.[3] CMS estimates that approximately 75% of nursing homes will need to hire additional registered nurses (RNs) and certified nurse aides (CNAs) to meet the proposed staffing requirements. Hiring in long-term care has long been a challenging process, but with unemployment at 3.8%, there simply aren't enough appropriately trained workers to fill existing open positions, before any proposed increases are put in place. Many nursing homes have already been forced to utilize staffing agencies – compromising quality and exhausting their reserves to cover prohibitive and unsustainable costs.

- **Licensed Practical Nurses (LPNs) were completely omitted from the staffing requirements.** The proposed rule fails to include the essential contributions of Licensed Practical Nurses (LPNs), who comprise 13% of the nursing home workforce and should count toward either the RN or CNA mandated ratios. LPNs contribute to resident care and quality of life, and these positions offer career ladders that provide opportunities for growth and promote staff retention.

[2] MACPAC. (2023, January 6). *Estimates of Medicaid Nursing Facility Payments Relative to Costs : MACPAC*. https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/

[3] Larson EH, Andrilla CHA, Garberson LA. Supply and Distribution of the Primary Care Workforce in Rural America: 2019. Policy Brief #167. WWAMI Rural Health Research Center, University of Washington; June 2020.

- **Mandating staffing requirements could decrease access to care across the continuum.** Both the acute and post-acute care sectors are seeing workers exit the profession, leaving a void that cannot be filled without bold action. Nursing homes have already reported increasing demands on their staffing resources. The existing workforce shortages are resulting in backlogs at acute care hospitals, which are unable to discharge residents due to reduced capacity in post-acute, long-term care facilities. Further, home care and hospice providers – already navigating workforce challenges – will be short of even more workers if they move to nursing homes. Shuffling the relatively small number of care workers available between settings won't solve the problem. And holding nursing homes to a standard that is impossible to meet because there are not enough workers in the country, then fining and penalizing them for not meeting that standard, is going to force quality of care down—not improve it.

Federal action on staffing mandates must be realistic to achieve its intended effect and should be paired with historic workforce investments, fair reimbursement rates and meaningful employment pathways for those entering the long-term care field. The current and highly fragmented approach to long-term care financing no longer serves the millions of residents across the continuum who require compassionate and highly skilled care. Medicaid, the dominant payer of long-term care services, doesn't fully cover the cost of care in nursing homes according to a recent MACPAC report[4]. Regulations and enforcement, even with the best intentions, just can't change that math.

We urge Congress to work with the Administration and long-term care stakeholders to develop and invest in a robust workforce development strategy and delay the proposed rule until there are enough qualified applicants and adequate funding to address staffing levels realistically throughout the long-term care continuum. Requiring mandates that are impossible to meet may make a convincing talking point but accomplishes nothing and gets in the way of making meaningful changes. The staffing ratio mandated in Rhode Island is an excellent case in point. Initially, the state delayed enforcement, recognizing there are insufficient funds and simply no people to hire. The delayed enforcement date has passed, but policymakers are not pushing to enforce the mandate because, it is not implementable. As a MedPAC commissioner said recently in regard to the proposed CMS mandate, this is the "definition of policy insanity."

Workforce Recommendations

LeadingAge suggests the following actions on workforce:

- Enact the *Protecting Rural Seniors Access to Care Act (H.R. 5796)* to prevent the rule's implementation and instead convene an Advisory Panel on the Nursing Home Workforce.
- Enact the *Expanding Care in the Home Act (H.R. 2853*) – of note is section 8 that looks at the future of the home-based care workforce with a focus on home-based nursing and grants to develop the home-based care workforce. The grant recipients should be expanded to include hospices.
- Enact the *Improving Care and Access to Nursing Care (I CAN) Act (H.R. 2713)* which would expand the authority of advance practice nurses.
- Enact the *Preserving Access to Home Health Care Act (H.R. 5159)* to ensure continued access to home health services.
- Enact the *Ensuring Seniors' Access to Quality Care Act (H.R. 3227)* bipartisan legislation to address a critical shortage of certified nursing assistants (CNAs)
- Enact the *Building America's Health Care Workforce Act (H.R. 468)* to extend the flexibilities of Temporary Nurse Aide training and certification requirements.

[4] MACPAC. (2023, January 6). *Estimates of Medicaid Nursing Facility Payments Relative to Costs : MACPAC*. https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/

- Enact the *Better Care Better Jobs Act* (HR 547) which would authorize increased FMAP percentages for home and community-based services and would require states use some of these dollars to support the direct care workforce. Enact meaningful immigration reform to enable qualified caregivers to legally enter the U.S. and work in long-term care settings.
- Direct HHS to establish and fully fund a national technical assistance center to support health and long-term care employees dealing with chronic workforce shortages.
- Direct HHS to create a standardized online training and testing program for Certified Nurse Aides (CNAs) and other allied health professionals.
- Direct HHS to review, and report to Congress, the current barriers for students seeking to complete training in long-term care and home and community-based settings. This should include master's and doctoral students completing required shadowing, training hours or internship placement.
- Direct HHS to provide a report to Congress outlining the role of Licensed Vocational/Practical Nurses across home and community-based care including home health, hospice, and PACE and congregate settings.
- Direct HHS to review opportunities to incentivize Graduate Medical Education (GME) slots for medical students who are completing training in geriatric medicine with rural healthcare providers.

Impacts of the Medicaid Access Rule

LeadingAge opposes the proposal that would require 80% of Medicaid funds to be passed through to direct care staff compensation until adequate data, rates, and funding are available to amend the proposal in a way that could be feasible for providers. LeadingAge strongly believes that the direct care workforce needs a range of supports to be successful including a living wage, but this proposal will not achieve the desired goal of appropriately compensated staff. Instead, it creates perverse supervisory and training incentives, is lacking adequate data on providers' ability to accomplish this threshold and would cause access issues due to providers' inability to meet the standard.

Budgets are already tight for Medicaid providers and the workforce problem creates an even more dire situation for our members. The combination of low reimbursement and a lack of available workforce is already creating access issues in the communities in which our members serve. One LeadingAge member, with an average daily census of 300 clients per day reports that her agency turned away **3200 clients in the month of September alone** due to lack of available staff**.** CMS' proposal would make this already dire access issue even worse – it does not give providers enough room in their budgets to cover necessary costs – including those important for high quality care, like training and supervision and critical investments in technology and long-term sustainability. If a provider were to remain operational in the face of this requirement, they may opt to maintain existing wages to try to achieve compliance and cut back on other administrative functions that support quality. If this provision is enacted as proposed, we will see more people go without care and not see the growth in wages that CMS and LeadingAge members are seeking. Data collection and infrastructure concerns also need to be addressed before a conversation about a passthrough could begin.

Most critically, a proposal like this cannot be implemented without federal and state investment. Quite simply, the math does not work and is only achievable if states allocate substantially more Medicaid dollars towards closing the gap that an 80/20 split requires. As mission driven providers of aging services – our members are already teetering on the edge of financial viability by offering these services through the Medicaid program. This proposal would make most if not all of them reconsider whether they could continue to provide care.

Specific concerns with the Medicaid Access proposal include but are not limited to:

- **Data supporting the 80/20 provision is weak:** There is not sufficient data to tell us what this type of proposal could look like without substantially more data collection particularly on rates, rate setting, and provider infrastructure. CMS presents no data to show why a threshold of 80% was chosen for this proposal. Only two states have attempted to implement any sort of similar passthrough – neither of which are at a threshold of 80%. We will hear from a provider in Illinois regarding the State's policy, why it is different, and how CMS did not take the requisite steps needed to begin to contemplate such a proposal.

- **Training is critical to high quality care and cannot be discounted as an important cost:** Each of the three proposed included services – home health, homemaker, and personal care -- which would be required to meet the proposed threshold have dramatically different training requirements. Our members underscore that training is an important investment in their workforce. [5] As staff competencies increase through additional training, providers can create internal certifications and offer additional wages. Currently, providers can incentivize employee loyalty through organizing and offering training that provides job ladders and lattices as well as opportunities for advancement within their field with their same employer. Imposition of the proposed threshold and definition of compensation would limit providers' ability to maintain these job training and promotional opportunities within their organization, thus stifling employee advancement and serving to undermine recent efforts to professionalize the direct care workforces.

- **The exclusion of clinical supervision in the threshold is a threat to quality care:** Possibly the most egregious perverse incentive that this threshold would invoke is a limitation on clinical supervision. One LeadingAge member noted limitations on RN to aide ratios are dependent upon travel distances between client residences. This proposal could *eliminate* access to services in rural and frontier areas of states because the 80/20 requirement would be more burdensome because rural providers cannot spread out the non-allowable costs across as large patient population. Another member noted that for very high acuity residents, aide services are assessed weekly. The same provider also noted a commitment to staffing continuity and noted the importance of manageable clinical supervisor to home health aide ratios to assure that aides always have access to clinical support. Disincentivizing strong clinical supervisory structures in these services, where aides are most apt to see changes in a person's condition, or be informed of a recent event (fall, self-administered medication error, etc.), will harm consumers, undermining service quality and lead to unnecessary critical incidents and emergency department utilization.

- **Rate and enrollment transparency is essential to developing any proposal around wages:** CMS's proposal to enhance rate and enrollment transparency is an essential precursor to any future work around a wage passthrough. CMS is proposing that states be required to develop an accessible website for rate and data transparency. Proposed requirements include current rate breakdowns by service type, geographic variation, and population characteristics. For services that are shared or similar across different service populations (consider personal care for aging vs individuals with an intellectual disability), those differences and specifics must be outlined. In many states, service definitions for the same service in different programs vary slightly, resulting in nominal differences in training requirements and substantially different Medicaid rates. It is well documented in research publications[6]

[5] https://www.ltsscenter.org/wp-content/uploads/2021/06/State_Sponsored_Home_Care_Aide_Training_Approaches.pdf and https://leadingage.org/wp-content/uploads/drupal/Workforce%20Vision%20Paper_FINAL.pdf

[6] https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/

and the press[7, 8] that inadequate Medicaid rates contribute to access problems as providers make decisions about whether to deliver those services under Medicaid reimbursements. CMS also did not contemplate rate adequacy in their proposal assuming states will figure it out – but Congress must contemplate additional Medicaid dollars if they want to support this type of proposal. Providers are also forced to assess losses on Medicaid programs and determine payer mix ratios to ensure ongoing business viability. CMS explicitly excludes these 80% threshold requirements in state plans. Promoting transparency across all administrative authorities will provide a holistic picture of a state's Medicaid payment policies.

- **Infrastructure to collect data to implement the passthrough does not exist:** As Medicaid programs vary, so too do states' data collection processes. Few states require cost reporting for home and community-based services. If CMS is serious about proposing any type of unform requirement regarding wages, the reporting structure needs to be universal – whether that be in the form of a cost report or some other mechanism. Any data collection infrastructure needs to be inclusive of the information on rates discussed above. We understand this poses generality concerns as uniform data reporting would be tremendously difficult with unique variability in state Medicaid programs. This is precisely the reason we urge careful consideration of broad payment allocation provisions, without adequate and specific data to support the proposal. Congress needs to fund CMS to build the requisite infrastructure.

- **Other administrative overhead is not contemplated in the proposal**: These items include geography and travel obligations between clients in rural areas; onboarding, completion of required training, and compliance with background check requirements are important, but costly to providers; administrative and billing burdens within Medicaid is inconsistent across states including; the cost and reimbursement of rent, cellphones, and other essential ancillary costs that improve quality and drive care. If this proposal were finalized, providers will not have the funds to keep operations running.

LeadingAge asks that CMS withdraw the passthrough proposal until necessary data, infrastructure, and funding exist to support a different proposal aimed at supporting the direct care workforce. We appreciate the opportunity to provide our written comments to the Committee and look forward to working with you on this and other policies that improve the provision of long-term care in America.

Thank you again to Chairs McMorris Rodgers and Guthrie and to Ranking Members Pallone and Eshoo for holding this hearing. Implementing these two rules as proposed, especially in tandem, would be devastating to the long-term care providers and worsen the already staggering workforce crisis.

[7] https://www.mcknights.com/news/81-percent-of-nursing-homes-receive-less-than-cost-of-care-for-medicaid-patients-analysis/

[8] https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact

LeadingAge Analysis: Additional Yearly Costs and FTEs to Meet Proposed Staffing Regulation 2023

LeadingAge: Additional Yearly Costs and FTEs to Meet Proposed Staffing Regulation					
State	SNF Count	Total Cost	Cost per SNF	Additional RN FTEs needed	Additional Aide FTEs needed
USA	14,993	$ 7,138,167,385	$ 476,100	26,753.97	85,364.39
AK	20	$ 267,118	$ 13,356	1.00	2.59
AL	225	$ 84,588,033	$ 375,947	407.09	1,077.08
AR	218	$ 73,024,240	$ 334,974	602.62	561.33
AZ	142	$ 60,657,017	$ 427,162	216.75	860.67
CA	1,170	$ 503,718,487	$ 430,529	2,905.01	2,741.29
CO	217	$ 75,765,820	$ 349,151	142.53	1,099.28
CT	203	$ 100,991,458	$ 497,495	279.81	1,421.19
DC	17	$ 5,112,301	$ 300,724	2.16	88.37
DE	44	$ 16,537,888	$ 375,861	22.34	235.61
FL	697	$ 244,901,445	$ 351,365	1,120.84	2,880.67
GA	357	$ 229,905,222	$ 643,992	996.76	2,857.78
HI	43	$ 7,888,335	$ 183,450	11.18	123.10
IA	411	$ 82,171,401	$ 199,930	342.71	1,018.23
ID	81	$ 15,487,298	$ 191,201	50.32	192.97
IL	693	$ 437,705,033	$ 631,609	1,039.29	6,322.96
IN	521	$ 190,167,002	$ 365,004	705.64	2,252.16
KS	313	$ 58,052,278	$ 185,471	296.53	615.87
KY	274	$ 87,887,974	$ 320,759	318.91	1,235.66
LA	269	$ 184,587,873	$ 686,200	1,336.61	1,658.95
MA	353	$ 204,949,869	$ 580,595	479.62	2,431.78
MD	225	$ 137,447,297	$ 610,877	220.29	1,948.58
ME	87	$ 7,452,067	$ 85,656	28.71	68.94
MI	430	$ 180,140,754	$ 418,932	592.29	2,286.83
MN	349	$ 83,803,783	$ 240,125	182.18	1,070.50
MO	509	$ 245,314,401	$ 481,954	1,321.95	3,007.75
MS	202	$ 64,861,987	$ 321,099	322.61	852.98
MT	62	$ 20,466,662	$ 330,107	55.21	257.05
NC	420	$ 207,303,426	$ 493,580	858.56	2,350.89
ND	76	$ 9,582,885	$ 126,091	42.99	61.59
NE	186	$ 36,693,759	$ 197,278	189.27	311.84
NH	73	$ 34,312,033	$ 470,028	59.79	403.71
NJ	348	$ 259,137,204	$ 744,647	626.96	3,336.77
NM	68	$ 29,598,258	$ 435,269	95.11	381.51
NV	67	$ 36,451,007	$ 544,045	103.06	487.40
NY	606	$ 644,023,777	$ 1,062,746	1,586.58	7,166.58
OH	946	$ 430,983,673	$ 455,585	1,389.86	6,228.55
OK	292	$ 95,882,192	$ 328,364	772.94	679.21
OR	129	$ 20,184,914	$ 156,472	130.83	49.85
PA	672	$ 463,393,312	$ 689,573	831.42	5,972.42
PR	6	$ 2,863,565	$ 477,261	0.05	60.78
RI	75	$ 23,881,093	$ 318,415	56.07	267.14
SC	188	$ 93,944,312	$ 499,704	383.54	1,149.84
SD	98	$ 18,677,719	$ 190,589	62.75	242.09
TN	311	$ 162,338,993	$ 521,990	602.08	2,246.51
TX	1,193	$ 721,780,385	$ 605,013	3,717.05	8,867.67
UT	98	$ 15,076,197	$ 153,839	25.12	278.18
VA	289	$ 230,824,163	$ 798,700	707.42	3,057.67
VT	34	$ 11,266,970	$ 331,381	31.81	98.47
WA	197	$ 46,695,176	$ 237,031	131.44	462.98
WI	331	$ 73,586,853	$ 222,317	170.42	1,058.46
WV	122	$ 56,636,571	$ 464,234	159.59	849.40
WY	35	$ 9,195,906	$ 262,740	18.36	124.71