May 12, 2025

The Honorable Russell Vought
Director
Office of Management and Budget
Eisenhower Executive Office Building
1650 Pennsylvania Avenue NW
Washington, DC 20503

Subject: Request for Information: Deregulation

Submitted Electronically via: www.regulations.gov

Dear Director Vought,

LeadingAge's more than 5,400 nonprofit and mission-driven aging services providers rely on the astute administration of federal statutory and executive directives by several federal agencies. The mix of health, housing, and social welfare programs that support our nation's 59.2 million older adults are complex and the regulations to carry them out must be attuned to various intersecting realities.

Federal regulations often fail to reflect the needs and realities of aging services providers, including the costs and administrative burdens they impose, and we therefore welcome this opportunity to share with you a list of opportunities to repeal and revise existing regulations, and in some cases to not ever implement proposed rules that have not been finalized. LeadingAge is also working directly with federal agencies to repeal and revise sub-regulatory directives that get in the way of providers serving older adult in ways that improve quality, access, and cost effectiveness.

Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS), CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Regulation: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

Request: LeadingAge requests that this rule be eliminated in its entirety.

2519 Connecticut Ave., NW | Washington, DC 20008-1520
P 202.783.2242 | F 202.783.2255 | LeadingAge.org

Code: 42 CFR 483.35(b) - (c), 42 CFR 483.71(b) – (c), and 42 CFR 442.43

The Minimum Staffing Standards for Long-Term Care Facilities final rule was published in the Federal Register on May 10, 2024. This rule requires nursing homes to have a registered nurse on-site twenty-four hours per day, seven days per week in every nursing home, regardless of the assessed needs of the unique resident population or the skills and competencies of the existing staff. The rule further requires all nursing homes to provide 3.48 hours per resident, per day or total nurse staffing, including 0.55 hours per resident, per day of registered nurse services and 2.45 hours per resident, per day of nurse aide services. This requirement exceeds the statutory requirement to provide 24-hour licensed nurse services sufficient to meet the needs of residents and to use the services of a registered nurse at least eight consecutive hours per day, seven days per week. Inability to meet staffing standards may cause nursing homes to limit admissions, take beds offline, or close entirely, resulting in barriers to access for older adults seeking skilled nursing or long-term care.

In May 2024, the American Health Care Association filed a lawsuit claiming, among other complaints, that the Centers for Medicare & Medicaid Services (CMS) exceeded statutory authority in issuing these requirements. LeadingAge joined the lawsuit in June 2024 as co-plaintiff. On April 7, Judge Matthew Kacsmaryk of the United States District Court for the Northern District of Texas, Amarillo Division, issued his decision finding that CMS indeed had exceeded statutory authority and vacating the requirements.

This rule contains two additional sets of provisions that are currently being challenged in the U.S. District Court for the Northern District of Iowa, Cedar Rapids Division. These provisions relate to enhanced Facility Assessment requirements and Medicaid institutional payment transparency. In the 2016 Mega Rule "Requirements for Participation in Medicare and Medicaid Programs," CMS finalized provisions requiring nursing homes to conduct, document, and annually review a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. In the 2024 Minimum Staffing Standards for Long-Term Care Facilities final rule, CMS added requirements "to ensure that facilities are utilizing the assessment as intended by making thoughtful, person-centered staffing plans, and decisions focused on meeting resident needs, including staffing at levels above the finalized minimums as indicated by resident acuity."

These provisions include incorporating evidence-based methods when care planning for residents; including input of nursing home leadership, management, direct care staff, and residents, resident representatives, and family members; and developing a staffing plan to maximize recruitment and retention of staff. While the minimum staffing standards were not scheduled for implementation until 2026 and after, all nursing homes were required to implement enhanced Facility Assessment requirements beginning in August 2024. The implementation of these requirements has caused considerable administrative burden on nursing homes who must now allocate staff time and resources to update this document that is largely viewed as a check-the-box exercise by providers and regulators alike. Nursing homes will continue to provide staff with the competencies and skills sets required to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident per requirements at 42 CFR 483.25 without taking time away from resident care to complete this unnecessary paper compliance.

The rule would also require Medicaid state agencies to report annually to CMS the amount of nursing home Medicaid payments spent on compensation of the direct care workforce. This reporting by state agencies would require reporting from individual nursing home providers to the state agency in order for the state agency to report the information to CMS. Reporting the amount of Medicaid payments

spent on direct staff compensation is an administrative burden that does not meet the intent of the requirement and creates opportunity for inaccurate conclusions to be drawn about Medicaid spending that could negatively and erroneously influence future policies. Requiring reporting on the percentage of Medicaid payments spent on compensation implies that compensation of direct care and support staff are the only valid uses of Medicaid dollars. In fact, there are many valid expenses outside of direct care staff compensation on which Medicaid payments are spent. Evaluating, testing, and revising emergency plans and updating resident rooms from multiple-occupancy to private rooms with improved ventilation are examples of important uses of nursing home funds that would be overlooked with this type of reporting requirement.

Regulation: Respiratory Illness Reporting

Request: LeadingAge requests that this requirement be rescinded as it is unnecessary and duplicative of other federal requirements.

Code: 42 CFR 483.80(g) Infection Control, Respiratory illness reporting.

Under infection control requirements, nursing homes must report information on acute respiratory illnesses, including influenza, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and respiratory syncytial virus (RSV) through a standardized format and frequency specified by the Secretary.

At present, this format and frequency is weekly reporting through the National Healthcare Safety Network (NHSN) system, an online reporting platform that is developed, maintained, and utilized by the Centers for Disease Control & Prevention (CDC). The data currently reported includes facility census, resident vaccination status for the three identified respiratory illnesses, confirmed cases among nursing home residents for each illness, and hospitalizations of nursing home residents for each illness.

Weekly reporting of respiratory illness data was initiated during the COVID-19 public health emergency. At that time, a strong federal response was needed to monitor this catastrophic new virus and coordinate state and federal strategies for preventing and responding to outbreaks. The data was used to learn about this novel virus as well as inform the distribution of supplies and support from the federal government to state and local governments and entities. However, we have learned much in the five years since this virus emerged and the impact of the virus has significantly changed.

We are no longer in a national public health emergency and the federal government is no longer involved in large-scale efforts to provide resources and support coordinated response to long-term care. Allocations of PPE from HHS ended mid-way through the PHE, and strike teams are also a relic of the early days. Similarly, while nursing homes continue to receive support from public health, these responses are local activities, not federal response efforts, and are driven by local conditions within the state or region rather than conditions across the country.

We note that public health entities would continue to have access to data on respiratory illness outbreaks, even without NHSN data, due to separate existing requirements to report outbreaks to public health authorities. Per these requirements, nursing homes would continue to report clusters of respiratory virus symptoms and confirmed cases to public health, allowing for continued situational awareness, support, and outreach.

Regulation: Civil Money Penalties: Basis for Imposing Penalty

Request: LeadingAge requests that this requirement be eliminated, as it imposes undue financial burden on nursing homes.

Code: 42 CFR 488.430 Civil Money Penalties: Basis for Imposing Penalty

Nursing homes are cited for noncompliance with Requirements of Participation through the survey and certification process. As a result of findings of noncompliance, CMS or the state may impose financial penalties on the nursing home in an effort to ensure a return to and maintenance of compliance. Requirements at 42 CFR 488.430 give CMS or the state survey agency the authority to enforce multiple financial penalties for a single type of noncompliance, such as per day and per instance civil money penalties, regardless of whether or not the deficient practice constituted immediate jeopardy.

Allowing CMS or the state to impose multiple penalties on the nursing home for noncompliance creates barriers to quality improvement. When nursing homes are assessed large fines for noncompliance that was promptly corrected, they have less money available for the care and services residents depend on. This means less money is available to recruit and retain staff, implement quality improvement initiatives, or make improvements to the physical environment such as renovating outdated physical structures to improve indoor air quality and accommodate private rooms.

Nursing homes facing extreme financial hardship may even be forced to make changes to operations including the need to reduce resident programs, reduce staff, reduce admissions, or close entirely, creating access issues for older adults seeking nursing home care.

Eliminating this requirement will lessen the punitive overreach of CMS and state agencies and allow providers more financial flexibility to address areas of noncompliance and needed quality improvement.

Regulation: Testing of Emergency Plans

Request: LeadingAge requests that this requirement be modified to reduce regulatory burden by requiring nursing homes to complete only one testing exercise per year, which shall be a community-based or individual facility-based full-scale exercise.

Code: 42 CFR 483.73(d)(2) Emergency Preparedness, Testing

Under Emergency Preparedness requirements, nursing homes must develop an emergency preparedness plan that is tested at least twice per year. One test must be a community-based or individual facility-based full-scale exercise. An example of a full-scale exercise would include multiple agencies, including the nursing home and other healthcare settings, emergency management partners, and community members simulating a natural or man-made emergency such as earthquake or cyber-attack. This would include acting out coordination, communication, evacuation, and resource allocation according to emergency plans to test response capabilities.

To meet requirements for a second test each year, nursing homes have the option to conduct an additional full-scale community- or individual facility-based exercise or to perform a mock disaster drill, a tabletop exercise, or workshop. For example, the nursing home may convene a meeting of personnel

in a conference room for an afternoon where they identify a hypothetical natural or man-made emergency and engage in group discussion to review step-by-step how this emergency would be handled according to the emergency plan, including problem-statements, directed messages, or prepared statements designed to challenge the emergency plan.

While some CMS-certified providers, such as nursing homes, are required to complete two tests per year, other CMS-certified providers such as Home Health Agencies are required to complete only one test per year. Not only is the requirement for two tests per year unduly burdensome, taking staff away from their responsibilities of caring for residents, but our members tell us that very little is gained from performing a second exercise each year, particularly those such as tabletop exercises and workshops. Modifying the requirement to eliminate the second annual exercise and requiring only one full scale community- or individual facility-based exercise each year will mean less time taken from residents for administrative exercises while ensuring a more meaningful experience from the remaining testing exercise.

Regulation: Resident assessment, Preadmission screening for individuals with a mental disorder and individuals with intellectual disability

Request: LeadingAge requests that this requirement be rescinded as it represents outdated and unnecessary requirements that are unduly burdensome.

Code: 42 CFR 483.20(k) Resident assessment, Preadmission screening for individuals with a mental disorder and individuals with intellectual disability

This requirement was implemented as a result of the 1987 Omnibus Budget Reconciliation Act (OBRA '87) to prevent unnecessary placement of individuals with mental illness or intellectual disabilities in nursing homes. Under these requirements, nursing homes must complete preadmission screening to determine that individuals with mental illness or intellectual disabilities require the level of services provided by the nursing home. These preadmission screenings require the state mental health or intellectual disabilities authority to make a determination based on an independent physical and mental evaluation performed prior to admission by a person or entity other than the state authority or nursing home. Both the evaluation and the determination by the state authority often require agency coordination that causes unnecessary delays in admission to the nursing home.

While inappropriate placement of individuals with mental illness or intellectual disabilities in nursing homes must still be prevented, requirements for pre-admission screening and referral as operationalized through 42 CFR 483.20(k) are unnecessary due to subsequent requirements implemented through the 2016 Mega Rule, "Requirements for Participation in Medicare and Medicaid Programs" that require resident assessment and care planning for all residents ensure that the needs of residents are identified and addressed, and that nursing homes do not admit residents whose needs they are unable to meet. Requirements at 42 CFR 483.30 require that physicians personally approve, in writing, recommendations for individuals to be admitted to the nursing home. According to requirements at 42 CFR 483.21(a)(1), nursing homes must assess a resident's needs and develop a baseline care plan within 48 hours of admission. Per requirements at 42 CFR 483.20(b) and 483.21(b), a comprehensive assessment must be completed within 14 days of admission and a comprehensive care plan developed within 7 days of the assessment, and both the assessment and care plan must be reevaluated upon a significant change in functioning or at least quarterly thereafter.

These requirements for assessment and care planning ensure that individuals with mental illness or intellectual disabilities are appropriately placed and that their needs are promptly identified and addressed. Eliminating PASARR requirements at 42 CFR 483.20(k) will lessen administrative burden on both nursing home providers and state agencies while also preventing unnecessary delays in admission for individuals in need of nursing home care.

Regulation: Training requirements

Request: LeadingAge requests modification of these requirements to allow flexibility for nursing homes to determine the most appropriate training topics and timelines for staff.

Code: 42 CFR 483.95 Training requirements

Finalized with the 2016 Mega Rule "Requirements for Participation in Medicare and Medicaid Programs", this requirement outlines specific training topics, timelines, and minimum hours of in-servicing training that nursing home staff must complete each year. This requirement fails to take into consideration other training requirements that are more appropriate to the role of the staff member, such as requirements at 42 CFR 483.35(d) that state the nursing home must ensure nurse aides are able to demonstrate competency in the skills and techniques necessary to care for residents' needs, 42 CFR 483.35(e)(7) that nursing homes review nurse aide performance at least annually and provide regular in-service education based on the outcomes of those reviews, 42 CFR 483.40(a) that staff possess appropriate competencies and skills sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, or any requirements specific to professional licensing for continuing education. LeadingAge recommends that this regulation be modified to remove prescriptive training topics and timelines and allow nursing home leadership to determine the most appropriate training for staff based on evaluation of existing competencies and skills sets and the unique needs of the resident population and nursing home operations.

Regulation: Methodology for Evaluating Home Health Patient-Driven Grouping Model Budget Neutrality

Request: LeadingAge requests the rescission of this methodology as it is not based on the best reading of the underlying statutory authority, and it exceeds the scope of power vested in the agency. Further, CMS should use its authority to prevent the application of additional permanent or temporary payment adjustments to this sector, which has experienced significant reductions in access over the last decade.

Code: 1895(b)(3)(D)(i) of the Social Security Act Methodology for Evaluating Home Health Patient-Driven Grouping Model Budget Neutrality

In the CY2022 Home Health Final Rule, LeadingAge holds that CMS incorrectly interpreted federal statute. Under Section 1895(b)(3)(D)(i) of the Social Security Act, CMS is required to reconcile payment rates from the patient-driven grouping model (PDGM) to achieve budget neutrality in comparison to the former Home Health Prospective Payment System (HHPPS) model through 2026. Section 1895(b)(3)(D)(i) states: *The Secretary shall annually determine the impact of differences between assumed behavior changes (as described in paragraph (3)(A)(iv)) and actual behavior changes on estimated aggregate expenditures under this subsection with respect to years beginning with 2020 and ending with 2026*.

CMS' CY2022 finalized methodology for assessing whether actual PDGM aggregate expenditures in 2020 equaled a budget neutral level in relation to the level of expenditures is not limited to a focus on PDGM assumed behavior changes. Those assumed behavior changes were related to the primary diagnosis, LUPA volume, and incidence of comorbidities. However, CMS included considerations of volume of therapy visit changes, contrary to the requirement to eliminate therapy thresholds in 2019. This change in therapy thresholds occurred one year prior to the implementation of PDGM and violates paragraph (3)(A)(iv), which clearly states assumed behavior changes are those "that could occur as a result of the implementation of paragraph (2)(B) and the case-mix adjustment factors established under paragraph (4)(B) …." Paragraph (2)(B) refers to the establishment of a 30-day episode of payment that began in 2020 under PDGM.

CMS must utilize a PDGM budget neutrality methodology that is solely focused on assumed behavior changes that were incorporated into the original 2020 rate setting. The National Association of Home Care and Hospice, now the Alliance for Care in the Home, initiated a lawsuit in July 2023 against the Department of Health and Human Services regarding this incorrect interpretation of statute. The lawsuit was dismissed April 26, 2023, on procedural grounds that administrative remedies had not been exhausted. The inappropriate interpretation of this statute has led to significant reductions in payment to Home Health Agencies (HHAs) over the last three years and has contributed to the decreasing number of HHAs nationally.

Regulation: 42 CFR §484.105 Home Health Agency Acceptance to Service

Request: LeadingAge recommends the rescission of this regulation because of its duplication of current regulatory requirements, its burdensome nature, and the costs it imposes on small entities.

Code: 42 CFR §484.105 Home Health Agency Acceptance to Service

In the CY2025 Home Health Prospective Payment Final Rule published on November 7, 2024, CMS raised serious concerns about a lack of public transparency in Home Health Agency (HHA) acceptance to service policies and whether referral sources, including patients and caregivers searching for home health services, currently have access to sufficient and timely information necessary to locate an agency that is capable of meeting each specific patient's needs. CMS believes this lack of transparency is the root cause of delays in accessing services. Accordingly, CMS proposed and finalized the § 484.105(i) HHA acceptance-to-service.

This is an unnecessary and burdensome duplication of already statutorily required information as part of an HHA patients' rights in Sec. 1891(a)(1)(E)(i-iv) as well as 42 CFR 484.60. CMS maintains that HHAs should leverage their partnerships throughout the stakeholder community to gain exposure to existing practices that could assist in minimizing facility burden associated with compliance. However, policies like these are often proprietary and inter-agency collaboration cannot be required. Further, CMS stated in the final rule that following the publication, interpretive guidance for the final policy would be released and will provide additional information regarding oversight and enforcement of the requirements. The requirements went into effect January 1, 2025, and guidance is still not published regarding compliance leaving many HHAs potentially out of compliance at no fault of their own.

Finally, in the final rule, CMS did not appropriately update the Information Collection Requirements to account for additional language stating the public information would need to be "as frequently as

services are changed." The language in the final rule only accounts for an update four to six times a year, however as outlined in numerous comments submitted to CMS, the availability of services changes on a weekly to daily basis, meaning the estimated cost to review and update public information would be significantly more than $41.70 per year or $398,860.50 a year for all agencies. If calculations incorporated the potential for services to change on a weekly or daily basis, the cost for the nation's 9,565 HHAs would be between $3,456,791 and $24,264,013.75 per year.

Regulation: Staffing Requirements for Home Health Initial and Comprehensive Assessment Visit

Request: LeadingAge believes this regulation must be replaced as it is inconsistent with statutory text, is outdated based on the experiences during the COVID-19 public health emergency which saw no adverse effects to a similar waiver and generally is a burden to home health agencies by not allowing them to utilize their staff to the full scope of their professional abilities.

Code: § 484.55(a)(2) and (b)(3)

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS waived the requirements at § 484.55(a)(2) and (b)(3) permitting rehabilitation professionals to perform the initial and comprehensive assessment in instances when both nursing and therapy services are ordered. This helped alleviate pressures on the nursing workforce during the PHE and allowed rehabilitation professionals to perform the initial and comprehensive assessment for patients receiving therapy services as part of the broader nursing and therapy care plan, to the extent permitted under State law, regardless of whether the therapy service established patient eligibility to receive home care. During the pandemic this was an invaluable tool to support patients and staff alike.

Additionally, Congress recognized the critical importance of all staff working to the top of their scope of practice when it incorporated the *Medicare Home Health Flexibility Act of 2019* into Division CC, section 115 of Continuing Appropriations Act of 2021, which established the permanent ability of occupational therapists (OT) to conduct the initial and comprehensive assessments for HHAs when OT or other therapy services were part of the plan of care.

Per OMB's RFI, LeadingAge has reviewed the statutory language regarding home health and there is no foundation for nurses being the only professionals allowed to perform initial and comprehensive assessments when other therapy services are part of the plan of care. This creates an unnecessary burden to providers and can delay the start of care for patients due to continuing shortages in nursing staff. Home health is an interdisciplinary benefit and should rely on the full team to quickly initiate services and fully evaluate patients. All three categories of rehabilitation professionals, OT, physical therapy, and speech language pathologists have curricular requirements included in the general clinical skills required to conduct the initial and comprehensive assessments, both in the identification of immediate care and support needs, as well as the assessment of the patient's general health, psychosocial, functional, cognitive, and pharmacological status. Nothing in the nature of these professionals would put at risk the health or safety of patients, indeed the removal of this regulatory barrier could lead to better outcomes for HHA patients overall.

Regulation: Who May Conduct the Face-To-Face Encounter and Certify Patients for Home Health Services

Request: LeadingAge requests this regulation be updated to conform with statutory authority because, in its current form, it is a burden to home health agencies by not allowing them to utilize non-physician practitioners (NPPs) (nurse practitioners, physician assistants, and clinical nurse specialists) to the full scope of their professional abilities based on the right of states to define those standards.

Code: §424.22(a)(v)(C), §424.22(v)(A)(2) and §484.2

LeadingAge recommends the Administration replace the regulations to align with the flexibilities granted by the CARES Act and eliminate unnecessary barriers to Medicare home health certification. Specifically, CMS should modify §424.22(v)(A)(2) and §484.2 to allow NPPs to certify beneficiaries for home health services in accordance with state laws. Additionally, CMS should amend §424.22(a)(v)(C) to remove the requirement that the certifying practitioner must conduct the face-to-face (F2F) encounter. Instead, the regulations should permit the certifying practitioner to document that a physician or an allowed NPP has conducted the F2F encounter.

The CARES Act was signed into law on March 27, 2020, providing critical relief in response to the COVID-19 pandemic. Among its provisions, the Act included the Improving Care Planning for Medicare Home Health Services Act, which expanded the authority of NPPs to certify eligibility and issue orders for Medicare home health services. Additionally, the Act introduced flexibility regarding who may conduct the F2F encounter, removing the requirement that only the certifying practitioner may perform this function.

On March 30, 2020, CMS issued an interim final rule with comment (IFC), Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency. This IFC included regulatory revisions under §424.22, granting NPPs the authority to certify and order home health services. However, CMS has not yet issued conforming regulations to reflect statutory flexibility on who may conduct the F2F encounter.

Despite the statutory provisions, the revised regulations at §424.22(a)(v)(C) limit the F2F encounter to the certifying physician or practitioner for patients admitted from the community. Additionally, regulations at §424.22(v)(A)(2) and §484.2 retain a requirement for NPPs to collaborate with physicians when certifying and ordering home health services, even in states that permit independent practice for advanced practice registered nurses (APRNs). This contradicts the CARES Act, which explicitly allows NPPs to practice in accordance with state laws without requiring physician collaboration and provides flexibility regarding who may conduct the F2F encounter.

The CARES Act clearly reflects congressional intent to authorize NPPs to certify and order home health services for Medicare beneficiaries in accordance with state laws. Furthermore, Congress explicitly granted flexibility regarding who may conduct the F2F encounter, ensuring greater access to care.

Regulation: Supervision of Home Health Aides

Request: LeadingAge believes this regulation must be replaced as it is inconsistent with statutory text and generally is a burden to home health agencies by not allowing them to utilize NPPs to the full scope of their professional abilities based on the right of states to define those standards.

Code: § 484.80(h) Supervision of Home Health Aides.

LeadingAge believes that these regulations must be replaced by the original CY2022 Home Health Proposed Rule language, which allows visits to be completed via audio-visual communications "not to exceed 2 virtual supervisory assessments per HHA in a 60-day period" and the semi-annual on-site visit focus on "a" patient the aide is serving, not "each" patient served by that aide. These regulations are simply too burdensome for home health agencies to successfully comply with and places a burden on agencies when there is not a discernible public benefit as evidence by the lack of quality concerns during the COVID-19 waiver period.

In the CY2022 Home Health Proposed Rule CMS proposed requirements for supervision of aide services at § 484.80(h)(1) and (h)(2), which was supported by the home health community as it was initially believed to be a regulation applied at the agency level, i.e. the individual aide level. The proposed regulation also provided flexibility in these supervisory assessment visits by using two-way audio-video telecommunications not to exceed two virtual supervisory assessments per HHA in a 60-day period. However, CMS finalized the regulation not as initially proposed. Instead, CMS stated their intention to apply the changes at the patient-level rather than the agency-level. They modified the semi-annual onsite visit to require that this visit be conducted on "each" patient the aide is providing services to rather than "a" patient. Additionally, they determined to permit only one virtual supervisory visit per patient per 60-day episode. Furthermore, CMS clarified a virtual visit must only be done in rare instances for circumstances outside the HHA's control and must have documentation in the medical record detailing such circumstances.

This change was unexpected by the provider community, which was not given an opportunity to comment on concerns with the ability to comply with the change. Since the final rule, agencies have struggled to comply with the requirement. While we strongly believe in the critical nature of supervision of aide services, the reality is there are simply not enough staff at agencies to consistently conduct a visit on "each" patient the aide is providing services to. During the COVID-19 PHE, the requirement for registered nurse supervision to home health aides was waived but virtual supervision was encouraged. There is no evidence that during this waiver period aide services were inappropriately performed and that care delivery suffered. In both the final and proposed rule, CMS stated that the regulatory impact is negligible. We do not believe that this assessment is accurate given the removal of additional flexibilities for audio-visual supervision and the change from agency to patient level semi-annual visits.

Regulation: Payment for Physicians, and Nurse Practitioner and Physician Assistant Services

Request: LeadingAge requests revision of this regulation as it is inconsistent with statutory text and generally is a burden to hospices by not allowing them to utilize nurse practitioners (NPs) and physician assistants (PAs) to the full scope of their professional abilities.

Code: 42 CFR §418.304 Payment for Physicians, and Nurse Practitioner and Physician Assistant Services.

LeadingAge recommends the Administration revise section §418.304 allow nurse practitioners to bill for services not described in paragraph (a) of such section in the same manner as physicians may bill for such services in accordance with paragraph (b) of such section. Such revision should provide that such services furnished by a nurse practitioner shall be payable at the percent of the physician fee schedule specified in section 1833(a)(1)(O) of the Social Security Act (42 U.S.C. 1395l(a)(1)(O)).

Currently, hospices are not allowed to bill employed or contracted nurse practitioner (NP) or physician assistant (PA) services for Part A unless they are the attending physician of that specific patient. Hospices are currently permitted to bill and receive payment for physicians who are providing this care either as hospice employees or under arrangement with the hospice. Hospices, on behalf of all physicians regardless of their employment with the hospice or attending status with a patient, can bill Medicare part A when physicians provide services above and beyond what is covered in the hospice benefit. Our intensive research has not identified any statutory text that requires NPs or PAs to be the attending physician in order for the hospices they are employed by or contracted with to bill Part A on behalf of NPs or PAs, with the acknowledgement that any billing for those professionals would be at the Medicare allowable rate.

This unnecessary, and statutorily incorrect exclusion in the hospice regulations creates significant burdens on providers and limits their ability to be nimble and innovative in the way they staff and contract for services. For example, inpatient hospice units, which serve the most critical hospice patients, utilize NPs and PAs to support patient care. They are often rounding on patients when emergencies arise and, while they provide care above and beyond what is covered in the hospice benefit at § 418.304(a), the hospice is unable to bill Medicare part A for the work of the NP or PA because they are rarely the patient's attending in the inpatient setting. The role of attending physician in hospice is meant to promote continuity of care that branches a patient's pre-hospice care into hospice. For example, attendings are often the patient's PCP who seeks to stay involved in the patient's care through the end of life. This is not intended as a mechanism to ensure payment of services rendered by PAs or NPs above and beyond the daily rate.

Regulation: Program for All-Inclusive Care for the Elderly (PACE) Effective Date of Enrollment

Request: LeadingAge requests that this rule be repealed and that CMS allow, instead, people to be enrolled into PACE programs upon eligibility rather than the first day of the next month.

Code: 42 CFR 460.158 Effective date of enrollment

This regulation unnecessarily requires the PACE enrollment date to be the first of the month, but the enrollment date could be included in the participant enrollment agreement. CMS could easily determine a way to pay providers on partial month capitation regimens as it does in all other programs. Because someone is only eligible for PACE when they meet the clinical eligibility criteria for a nursing home, limiting PACE enrollment to the first of the month is a barrier to accessing life-saving services.

This outdated rule puts the wellbeing of people with notable physical or cognitive limitations in jeopardy and can cause significant health decline before a PACE program is allowed take the person in on the first of the next month. The rule then translates into unnecessary spending on preventable deterioration because the diagnoses of people delayed enrollment then contribute to PACE organizations' Risk

Adjustments, resulting in higher payments. This offsets the costs to PACE organizations but could have been avoided both by the PACE organization and CMS if the person were able to be admitted at the time they found out about the program and were deemed to be eligible.

Regulation: Limit on number of PACE program agreements

Request: LeadingAge contends that this provision is outdated and can be struck without effect.

Code: 42 CFR § 460.24 Limit on number of PACE program agreements

This section limits the total number of PACE programs that can be operational through a date set more than 25 years ago. LeadingAge contends that this provision is outdated and can be struck without effect.

Regulation: PACE marketing restrictions

Request: LeadingAge requests the elimination of provisions that limit the ability of PACE organizations to engage in direct marketing.

Code: 42 CFR 460.82(e)(5) PACE direct marketing

The CMS provision that limits the ability of PACE organizations to engage in direct marketing is strongly worded and can be construed to mean that no unsolicited marketing is allowed. This provision should be completely eliminated.

Other limitations on PACE marketing, including related to the extent of services, enrollment procedures, and approval by CMS of all materials, ensure that when marketing is done to PACE-eligible individuals they will not be misled.

PACE is a program uniquely customized for dual eligibles, but current marketing restrictions prevent PACE organizations from directly promoting their services. This places both PACE programs and dual eligible beneficiaries at a disadvantage when evaluating Medicare options. Unlike Medicare Advantage (MA) and Special Needs Plans, PACE programs are not listed on the Medicare Plan Finder, and Medicare plan brokers often lack sufficient knowledge about how PACE compares to MA-only or Special Needs Plans. As a result, Medicare beneficiaries who could benefit from PACE are not fully informed of all their options, since PACE programs are restricted from direct marketing.

Regulation: Medicaid Access Rule's 80/20 wage passthrough requirements

Request: LeadingAge requests the repeal of the Medicaid Access Rule's "80/20" provisions within 42 CFR 441.302(k).

Code: 42 CFR 441.302(k) HCBS payment adequacy

The requirements in §441.302(k)(1-8) that 80% of providers' Medicaid rates for homemaker, home health, and personal care services are passed on to workers via compensation. This requirement is

unattainable for many providers, particularly those with high Medicaid Payer mix, those in rural areas, and smaller organizations. Though we feel states should continue to demonstrate, via state assurances in §441.302(k), that rates are adequate to maintain a robust provider network and therefore access to services, the limitations of what counts towards the 80% threshold along with the significant increase in reporting burden for providers makes §441.302(k)(1-8) unworkable and should be struck from the regulation.

Providers of these services have significant fixed costs that make this threshold unworkable. For example, one federal mandate that has increased costs for providers of HCBS is the requirement to implement electronic visit verification (EVV). This tool is used to help states track that services billed via Medicaid were indeed delivered. EVV typically involves a direct care worker calling to clock-in upon arrival at a Medicaid recipient's home or using an app on their phone to do the same. Tracking is typically geolocated or triangulated to assure the proper location of the client's home. Through EVV implementation, providers are now required to connect to their state's EVV vendor and provide telecom devices or stipends to their staff. States received no additional funding to implement the requirement, and providers have not received rate increases to offset the administrative burden or the telecommunication costs associated with compliance. Good providers are in favor of strong program integrity but unfunded mandates make maintenance of a viable businesses difficult.

Additionally, the regulatory rationale for adopting the wage pass through was based on the experience of two states with wholly different rate structures and different thresholds. Without standardization of service definitions, additional data collection to understand an appropriate threshold, assessment of state rates for these services, and implementation of standardized data collection, those data will be inconsistent and irrelevant.

Regulation: HCBS Settings Rule / Home and Community-Based Services: Waiver Requirements

Request: LeadingAge requests that aging services providers be carved out of compliance efforts of the HCBS Settings Rule.

Code: Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers

The Settings Rule continues to be problematic in state interpretation of compliance for aging services providers. The settings rule intended to codify a set of principles that promote human dignity, independence, and engagement for individuals that receive Medicaid-funded community-based services. The final rule does not serve older adults well. For the aging population, more focus must be on keeping people safe and preserving function. A majority of individuals served in adult day programs or assisted living communities cope with cognitive deterioration or an outright dementia diagnosis.

One of the rule's provisions has been interpreted by states as requiring adult day providers to take attendees out of the center on 'field trips.' The attendees at the day center live independently in homes miles from the center, some alone, and some with caregivers. The trip to the day center *is precisely* that person's integration into the community. At the adult day program, the attendees will socialize with others, play games, engage in habilitative exercises, where appropriate, and enjoy the time away from their homes.

Other providers have struggled with ways in which their state is enforcing conflict free case management requirements. These provisions disallow case management and other services like home care to be provided by the same organization. Some high-quality providers of both services and case management have been driven out of a particular service line or forced into costly contracting arrangements to continue provision of both.

The rule includes exceptions and processes for which providers can document why or how they are complying with the spirit of the rule, even if a specific citation remains in conflict. The required documentation for every provision in the rule is costly in staff time and financial burden attributed to administrative tasks over care and interaction with residents or participants.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE FOR CIVIL RIGHTS

Proposed Regulation: HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information (Docket ID: HHS-OCR-2024-0020) 45 CFR Parts 160 and 164

Request: LeadingAge requests that the Office for Civil Rights (OCR) withdraw the proposed rule or, alternatively, that OCR make significant changes to it prior to issuing a final rule.

Proposed rule: Health Insurance Portability and Accountability Act Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information

The proposed rule seeks to update and strengthen the Health Insurance Portability and Accountability Act (HIPAA) Security Rule through extensive new administrative, technical and physical safeguard requirements, including removing the distinction between "required" and "addressable" implementation specifications.

We support the goal of strengthening data security and protecting the confidentiality, integrity, and availability of ePHI, and aging services work diligently to ensure their systems deliver proper protection. However, the depth and breadth of the proposed requirements, which would arrive without funding support and on an unreasonable timeline, would impose significant and unreasonable burdens.

The proposed requirements would place heavy administrative burdens and financial costs on aging services providers. In part, this is because these providers did not receive federal HITECH incentives for the adoption of health information technology. As a result, they have less digitally mature systems than hospitals and other providers that received incentives, and they would have significantly farther to go to achieve compliance. More importantly, this is because the rule would apply the standards and specifications equally to all HIPAA covered entities, from small providers to the largest of health systems, and to health plans and clearinghouses. The reality is that not all regulated entities are similarly situated, and OCR should not seek to regulate them as if they were. Breaches of the ePHI held by some organizations pose significantly higher risk for industry disruption than others, and some regulated entities have significantly greater capacity than others to meet the proposed standards.

If OCR moves forward with this proposal, it must further engage with the regulated entities the rule would impact, to build deeper understanding of feasibility, consider flexibilities for organizations with fewer resources and less mature systems, and prioritize reasonable requirements that reduce risks in a

meaningful way without unduly impacting workflows or reducing time spent in direct service to residents, clients and patients.

DRUG ENFORCEMENT ADMINISTRATION

Proposed Regulation: Special Registrations for Telemedicine and Limited State Telemedicine Registrations

Request: LeadingAge requests the rescission of this proposed rule based on its burdensome nature and the costs imposed on small entities, and for the Administrator of the Drug Enforcement Administration (DEA) and the Secretary of Health and Human Services to use existing authority, provided them by the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, to jointly provide exemptions to hospice and skilled nursing providers from any future similar rules.

Code: DEA-407: Special Registrations for Telemedicine and Limited State Telemedicine Registrations.

LeadingAge also strongly encourages DEA to revise these rules, in consultation with stakeholders, to further account for providers who serve equally vulnerable individuals outside of nursing homes and hospices, including providers serving palliative care patients and home health patients.

LeadingAge understands the difficult situation the DEA finds itself in regarding protecting against the abuse of controlled substances while also ensuring Americans can access needed medicine and use telemedicine consultations as a method of access. LeadingAge also agrees that guardrails are needed around telehealth utilization broadly and most especially when there is a high-risk situation such as overprescribing of controlled medications. However, LeadingAge is gravely concerned that the proposed rule laid out by DEA will only further limit access to critical drugs for the vulnerable older adults LeadingAge members serve.

As we outlined in great detail in our March 18, 2025, comment letter responding to the proposed rule for e-prescribing of controlled substances, we do not believe prescribing controlled medications using telehealth for hospice patients or residents in long-term care is a high-risk situation that requires the guardrails outlined in DEA's proposed rule. Furthermore, the consequences of adding additional oversight to hospice and skilled nursing clinical practitioners, especially with requirements for prescribing schedule II-controlled substances which are critically needed in these settings, would not only be burdensome but would also create catastrophic access issues for the older adults these settings serve. We are most concerned regarding the unduly restrictive nature of the guardrails for schedule II-controlled substances which are commonly found in these care settings.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Regulation: Phased Implementation Waiver for FY 2022 and 2023 of Build America, Buy America Provisions as Applied to Recipients of HUD Federal Financial Assistance

Request: Reinterpret applicability of all Build America, Buy America (BABA) Act requirements for affordable housing construction and renovation, including replacement of the phased-in implementation schedule with a full waiver.

Requirements: Phased Implementation Waiver for FY 2022 and 2023 of Build America, Buy America Provisions as Applied to Recipients of HUD Federal Financial Assistance

The Office of Management and Budget and the Department of Housing and Urban Development (HUD) have interpreted, via regulation, the Build America Buy America Act (BABA) as establishing a new domestic procurement requirement for construction and manufacturing products, as well as all iron and steel products, used in the construction, alteration, maintenance, and repair of infrastructure in America, including for constructing and rehabbing affordable rental housing in America.

BABA requirements substantially increase costs and add time to housing development and preservation. In addition, federally subsidized, private rental housing does not align with congressional intent for inclusion in new domestic procurement requirements for public infrastructure and therefore should not be subject to BABA requirements. BABA requirements substantially increase costs and add time to housing development and preservation.

Even without a Buy America Preference, current awardees of HUD's Section 202 Capital Advance funding to create housing for older adults connected to services and supports have experienced significant increases in construction costs and project delays resulting from product unavailability; the cost increases still threaten to entirely derail already approved and future funding for housing developments.

We urge HUD and OMB to reinterpret BABA's applicability to HUD programs or to waive BABA requirements for all federally subsidized housing programs. This would significantly improve costs and timelines for affordable housing construction and renovation and drastically improve affordable housing supply for older adults. With two out of every three eligible older adult renter households remaining unassisted by housing programs, the country cannot afford to lose a single new or existing unit of affordable housing.

Regulation: Requirements for environmental reviews under the National Environmental Policy Act

Request: LeadingAge requests that HUD relieve burden by relaxing requirements for environmental reviews under the National Environmental Policy Act (NEPA).

Code: 24 CFR 58.22(a)

In order to prevent adverse environmental impacts resulting from federally supported construction activities, HUD-assisted development is subject to environment site reviews through the National Environmental Policy Act (NEPA). In the context of HUD's NEPA compliance (24 CFR 58.22(a)), HUD prohibits recipients and their partners from taking any "choice-limiting actions" (CLAs), such as property acquisition, repairs, and site improvements that would limit the project's future alternatives, before a project's environmental review is completed.

Prohibiting properties from taking time-sensitive actions early in the development stage adds burden, time, and processing involved in development and preservation transactions. LeadingAge recommends that HUD adjust its environment review regulations, including by relaxing what constitutes a "choice limiting action," to provide flexibility in the early stages of development. allowing them to leverage

other funding sources and maximize resources at the site. Similarly, properties that have recently received federal assistance should be allowed to certify that there are no substantially altered environmental factors at the site to relieve significant burden.

Streamlining the process for development and preservation will ultimately help improve the supply of affordable senior housing for older adults and is a critical step to reducing burden for housing providers and developers to participate in federal housing programs.

Regulation: Previous Participation Reviews

Request: LeadingAge requests that HUD review burden for affordable housing providers participating in HUD programs and activities and that it eliminate redundancies associated with "previous participation" reviews for housing providers within the same calendar year or one-year timeframe.

Code: 24 CFR § 200.220

When a potential housing provider wants to engage with HUD programs and activities, the agency reviews the suitability of that entity for responsibility and acceptable risk (see HUD Notice H 2016-15). The review evaluates financial, legal, and other obligations by the potential participant and is triggered by a variety of events, such as new housing contract assignments, change in ownership, and applications for funds or FHA insurance.

Currently, the previous participation status is reviewed for each transaction that an entity undergoes, causing burden and redundancy for owners who have already been reviewed on a separate transaction during the same year. We recommend that HUD eliminate redundancies associated with "previous participation" reviews for housing providers within the same calendar year or one-year timeframe. Reducing the review frequency will remove barriers to participate in HUD-assisted programs serving older adults with low incomes without compromising the integrity of program participants. It will also free up HUD and property owner time for critical housing activities.

Regulation: Requirements regarding transfer of Section 8 contracts

Request: LeadingAge recommends that HUD streamline the transfer process for project-based rental assistance.

Requirements: HUD Notice H 2015-03 and subsequent guidance here and here.

Section 8(bb) of the US Housing Act of 1937 (42 U.S.C. 1437f(bb)) allows HUD to preserve the agency's budget authority for project-based Section 8 when a contract is terminated or not renewed. HUD issued guidance via HUD Notice H 2015-03 in 2015 on Section 8(bb) transfers and provided a memo in 2018. HUD's 2024 guidance on contract bifurcation also relates to Section 8 transfers.

LeadingAge members report that the current transfer process is exceedingly burdensome, including finding a suitable new owner, addressing budget neutrality, and financial coordination with HUD. In addition, HUD's current policy is to consider certain types of transfers on only a case-by-case basis. We recommend that HUD streamline the process and requirements for Section 8(bb) transfers.

Streamlining should include a simplified and clearly defined process and checklist of required documents and timelines.

Transferring Section 8 budget authority to a new owner or entity is a critical tool to maintain affordable housing units and ensure high quality, committed owners are participating in HUD's programs. Streamlining the Section 8 transfer process will smooth transactions while ensuring the process does not result in the loss of assistance for the families who were assisted at the initial property. The process would also still ensure that owners receiving the subsidy have the experience, capacity and commitment to provide high quality affordable housing over the long term.

Regulation: Section 202 Capital Advance award process and requirements

Request: LeadingAge urges HUD to establish a financial floor at which capital advances will be awarded that improves the feasibility of the awards and remove certain requirements for site and neighborhood standards.

Requirements: HUD Section 202 Notices of Funding Opportunities and 24 CFR 891.125

When appropriated funds by Congress, HUD awards Section 202 capital advances for new affordable housing for older adults with very low incomes. The awards are selected through a competitive application process that incentivizes certain types of projects or project elements.

In our membership's experience, certain HUD Section 202 capital advance selection approaches reduce project feasibility and run counter to the mission of housing older adults. For example, HUD's approach for several years has been to issue Notices of Funding Opportunities (NOFOs) that require significant leveraging of other, non-Section 202 capital funds to be selected by the agency for a Section 202 award. This forced leveraging results in a highly complex capital stack – often consisting of more than ten different sources for a single Section 202 award – that is much more expensive and much less efficient to produce; housing providers spend much more money on legal fees to ensure compliance and coordination between the various funding sources. We recommend that HUD establish a financial floor at which capital advances will be awarded that improves the feasibility of the awards.

In addition, HUD should remove certain site and neighborhood standards, including the minority elderly concentration component of the award selection process, to allow otherwise highly qualified proposals to be eligible for the awards.

Regulation: Federal Labor Standards Requirements in HUD Programs

Request: LeadingAge recommends that HUD work with the Department of Labor to adjust Davis-Bacon applicability in certain circumstances.

Requirements: Federal Labor Standards Requirements in HUD Programs

Relax "Davis Bacon" requirements for affordable housing renovations and other housing supply actions. The Davis-Bacon Act of 1931 requires the payment of locally prevailing wages and fringe benefits on federal contracts for construction. By requiring the payment of minimum prevailing wages, Congress sought to "ensure that Government construction and federally assisted construction would not be

conducted at the expense of depressing local wage standards." LeadingAge appreciates the spirit of the law and understands how wages directly influence one's ability to afford housing, among other necessities. However, HUD's implementation of Davis-Bacon has run afoul of reasonable expectations of this law.

Because paying prevailing wages contributes to major cost increases at federally assisted affordable housing projects, LeadingAge recommends that HUD work with the Department of Labor to adjust Davis-Bacon applicability so that certain wage requirements would not apply to affordable housing, for example to renovations of existing, federally-subsidized affordable housing properties, especially high-rise apartments that currently result in "high rise" wages, even where the renovations take place indoors with limited impact resulting from the height of the building.

Additional streamlining of the DOL's "Updating the Davis-Bacon and Related Acts Regulations," effective in October 2023, may be warranted.

Because no new project-based Section 8 contracts and properties are currently being created, affordable housing providers need relief from cost burdens associated with renovating and preserving the existing affordable senior housing stock. Relief from this requirement would allow owners to invest more funds in the capital repairs of their affordable properties.

DEPARTMENT OF LABOR (DOL)

Regulation: Restrictions on Operation of Power-Driven Patient Lifts

Request: LeadingAge requests that the Department of Labor remove the operation of power-driven patient lifts from the list of activities that the Department's Hazardous Occupations Order (HO) 7 prohibits, as the Department previously proposed in September 2018 (Expanding Employment, Training, and Apprenticeship Opportunities for 16- and 17-Year-Olds in Health Care Occupations Under the Fair Labor Standards Act (WHD-2018-0002-0001)).

Code: 29 CFR 570.58 -- Occupations involved in the operation of power-driven hoisting apparatus (Order 7)

The Fair Labor Standards Act (FSLA) ensures that when youth work, the work is safe and does not jeopardize their health, well-being, or education. The FLSA provides for a minimum age of 18 years in occupations found by the Department to be particularly hazardous or detrimental to the health or well-being of children 16 and 17 years of age. The Department has issued Hazardous Occupations Orders (HO) under these provisions. In 2010 the Department amended Hazardous Order 7 to, in part, eliminate a longstanding exemption for electric or air-operated hoists not exceeding a one-ton capacity. As a result, HO 7 encompasses power-driven patient lifts used to transfer residents in nursing homes and assisted living settings, for example. The Department later issued a non-enforcement policy (Field Assistance Bulletin No. 2011-3) but with limiting restrictions, including a requirement that lifts be operated by an adult with the teen allowed only to provide assistance.

Aging services providers across the U.S. are burdened by significant workforce shortages, which often limit the number of individuals they can serve. At the same time, 16- and 17-year-olds are seeking meaningful opportunities to gain valuable work experience, skills and exposure to career pathways in

caring for others. Also, as the Department's 2018 notice of proposed rulemaking recognized, the practical effect of the current policy often necessitates that younger employees in health-related occupations lift residents and clients manually – a practice that OSHA advises providers to minimize in all cases and eliminate when feasible.

The current rule on the operation of patient lifts restricts employment opportunities for young workers without enhancing their ergonomic protection. The ability for appropriately trained 16- and 17-year-olds to operate power-driven lifts independently will expand opportunities for young workers to play an important role in serving older Americans and gain a valuable start toward leadership in the field of aging services.

Regulation: Overtime: Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales, and Computer Employees

Request: LeadingAge supports the Department of Labor's decision to reconsider the Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales, and Computer Employees Final Rule published on April 26, 2024. LeadingAge requests that DOL provide opportunity for public comment and apply a methodology that leads to a reasonable increase to the minimum salary level required for overtime exemption, such as the one that would have taken effect July 1, 2024, under the now-vacated rule.

Code: 29 CFR 541.600 -- Amount of salary required; 29 CFR 541.601 Highly Compensated Employees

LeadingAge supports the Department of Labor's decision (as noted in its April 24, 2025, Unopposed Motion to Hold Appeals in Abeyance in the Fifth Circuit Court of Appeals (Nos. 24-40777, 25-10349)) to reconsider the Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales, and Computer Employees Final Rule published on April 26, 2024.

The 2024 final rule increased the minimum annual salary required for executive, administrative and professional employees (and for highly compensated employees (HCE)) to be classified as exempt from overtime. It set the standard salary level at the 35th percentile of weekly earnings of full-time salaried workers in the lowest-wage Census Region and the HCE total annual compensation threshold at the annualized weekly earnings of the 85th percentile of full-time salaried workers nationally. The result for the standard salary was a 65% increase from $35,568 to $58,656 annually. The rule also required DOL to update the salary level every three years, without a notice and comment rulemaking process.

It is appropriate for the Department to update periodically the minimum salary level required for overtime exemption. Aging services providers are deeply committed to their workforce and to providing competitive compensation. However, the cost of the increase established by the 2024 final rule would have been very difficult for many organizations to absorb without significant impacts to their operations. Further, automatic adjustment of the monetary threshold for the salary test cuts out the critical role that regulated entities play in informing the Department about the costs and impacts of changes to the salary level.

Aging services providers unable to absorb the full increased labor cost of the 2024 final rule (not to mention indirect costs) would have been required to make challenging decisions, such as reducing non-essential services and programming, affecting the quality of life for those they serve, or, alternatively,

choosing to serve fewer individuals. As the Department proceeds with decision-making about how to address overtime thresholds differently than the prior administration, we ask that it provide opportunity for public comment and apply a methodology that leads to a more reasonable increase, such as the one that would have taken effect July 1, 2024, under the now-vacated rule.

In conclusion, as the number of older adults in the United States is projected grow from 59.2 million in 2024 to 82 million by 2050, now is the moment to rectify past federal regulatory overreach and missteps negatively impacting the ability of aging services providers to improve program quality, access, and cost effectiveness.

Please reach out with any questions to Linda Couch, Senior Vice President, Policy and Advocacy, lcouch@leadingage.org.

Thank you for considering our comments.

Sincerely,

Katie Smith Sloan
President and CEO