



# Tribal Technical Advisory Group



## To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

November 6, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention: CMS-3442-P, P.O. Box 8016  
Baltimore, MD 21214-8016

*Submitted via regulations.gov*

**Re: Comments of the CMS TTAG on the Proposed Minimum Staffing Standards for Long Term Care Facilities Proposed Rule**

Dear Administrator Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to request that CMS withdraw its Notice of Proposed Rule Making CMS-3442-P (NPRM), which would force many nursing homes to close, threatening resident access to direct service. In the alternative, I request an overall exemption for Tribal long-term care (LTC) facilities from the proposed staffing standards outlined therein.

While there is a recognized need to ensure that private, large-scale residential operations adequately provide the high-level of care needed to the residents they serve, Tribal LTC facilities are operated by Tribal governments and their agencies, and are thus unlike those facilities which the Administration seeks to improve under this proposed rule. By contrast, each Tribal LTC facility provides an exceptional level of care in a manner that supports the unique culture of each resident and patient. This is a care model that no private facility can duplicate and thus fills a significant need in Indian Country.

Tribal long-term care facilities receive no funding from the Indian Health Service (IHS) and, are nearly entirely dependent on Medicare and Medicaid funding to operate. As a result, if proposed staffing standards like these are too expensive or not possible to meet due to staffing shortages, Tribal LTC facilities will simply cease to exist, and there will be no more long-term care in our communities. IHS and Tribally operated facilities have been designated Auto-Health Professional Shortage Areas (Auto-HPSAs) by HRSA for good reason. The Indian health system has been—and continues to be—chronically and woefully underfunded, and because of this, faces extreme challenges in attracting qualified health professionals. A General Accounting Office (GAO) study

found that the overall health professional vacancy rate for IHS was 25 percent, ranging from 13 to 31 percent across the IHS areas.<sup>1</sup>

Our Tribal leadership understands that the proposed standards contain delayed implementation for rural facilities, this will only delay the inevitable, which is the threat of closure. In the end, however, the requirements of the NPRM could effectively eliminate a critical, and already limited service in Indian Country.

- To understand the landscape of residential LTC in Indian Country, one has only to look to states such as Alaska, Oklahoma, and California. There are approximately 229 Alaskan Native communities within the state of Alaska. These Tribal communities spread across a vast terrain of 586,412 square miles, but there are only four Tribally operated nursing homes that serve the Alaskan Native population.
- In Oklahoma, there are 38 federally recognized Tribes served by only one Tribal LTC facility in the northeastern corner of the state. For Tribal members of the Kiowa, Apache, and Comanche Tribes who are located in and around Lawton, OK, the distance to receive culturally sensitive residential care is 184 miles. This is an approximately 3-hour trip, one-way, and is a significant burden to seek culturally competent care, to say nothing of the imposition on family members supporting and visiting their loved ones.
- In California, there are 109 federally recognized Tribes, and unfortunately there are not any Tribally operated LTC facilities. The proposed rule limits the options and feasibility for Tribes to develop important LTC facilities.

The unfunded mandate of the NPRM will not only threaten existing Tribal LTC facilities, but it has the potential to thwart the development of new LTC facilities throughout Indian Country. The NPRM fails to meet the requirements of the Unfunded Mandates Reform Act due to its impact on tribal governments, despite the statement in the NPRM to the contrary. This seems to be in direct conflict of the Executive Order released on April 18, 2023 which notes the need for dedicated federal funding to LTC in Indian Country alongside the need for additional staffing resources – a recognized need that has yet to be addressed.

## **I. Severe Nursing Shortages Exist in the Tribal Health System**

The current lack of funding for Tribal LTC facilities means that Tribes are primarily dependent on Medicare and Medicaid for operational costs. While the aforementioned Executive Order acknowledges these needs, there has yet to be a proposed action plan to realize meaningful financial support to Tribes. To meet the NPRM standard of 24-hour onsite oversight of a registered nurse (RN), a Tribal facility would be required to hire a minimum of 3 full-time RNs.

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<sup>1</sup> "Indian Health Services: Agency Faces Ongoing Challenges Filling Provider Vacancies," General Accounting Office, (GAO-18-580), August 2018.

In addition to the cost-burden, Tribes are facing the same shortage of healthcare staffing resources as other rural systems following the COVID public health emergency (PHE). However, for Indian Country, this shortage existed prior to the PHE due to the super-rural locations of most Tribal and Native Alaskan communities coupled with lower financial capacity to incentivize healthcare providers to serve their areas. This shortfall has been exacerbated by the PHE, making the NPRM staffing requirements an impossible barrier to LTC in Indian Country. This is documented in a GAO report, which explains that 27 percent of the total positions for nurses across eight IHS Areas were vacant, and that this vacancy rate ranged from 10 percent in the Oklahoma City area to 36 percent in the Albuquerque and Bemidji areas.<sup>2</sup>

In an April 2023 article, the American Hospital Association noted that over 100,000 RNs have left healthcare since 2020 as a result of the demands and stress of the PHE. The National Council of State Boards of Nursing noted survey results indicating that an additional 610,388 additional RNs intend to leave the profession within the next 4 years. These RNs are therefore expected to leave the profession a full year before the NPRM's 5-year implementation time frame. Tribally operated residential LTC does not have a chance to survive these tremendous blows, and so we are asking for a complete exemption for Tribal LTC facilities from the requirements proposed under the NPRM.

As our Tribes have been working to build self-sustaining long-term care, we have slowly but surely seen improved health outcomes of complex care needs and high levels of patient satisfaction as more of our vulnerable Elders and adults are able to remain in their own communities and maintain the contact with family, friends, and culture that is so important to positive care outcomes. The effects of our efforts can be found in data produced by the National Resource Center for Native American Aging (NRCNAA) at the University of North Dakota. The NRCNAA is one of three federally supported Tribal aging resource centers and has administered a quality of life and health survey of Elders nationwide since 1998. The survey is performed in three-year cycles and in the current results release, 75.5 percent of Elders with Alzheimer's or dementia-related illness and their caregivers reported feeling "well supported" by their Tribal programs while 85 percent believed that their wishes for the type of care they wanted to receive were listened to and respected.

If Tribal facilities are forced to close, our vulnerable and medically fragile community members will once again be facing reductions in appropriate care and below average outcomes; results that are directly at odds with the Administration's focus on health equity and improved access and care for Indian Country. Beyond the obvious blow to LTC in Tribal communities, the TTAG has these additional concerns regarding the overall process leading to this proposal.

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<sup>2</sup> "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies," p. 13, General Accounting Office, (GAO-18-580) (August 2018).

## II. Tribal Consultation

Despite CMS's clearly defined obligation to consult with Tribes on federal policies of impact to Indian Country, the TTAG is concerned that CMS did not engage in meaningful discussion or consult with us before rolling out this sweeping reform proposal. This obligation is rooted in the U.S. Constitution, federal statutes, federal regulations, Executive Orders, agency policies, and treaties. To meet these statutory requirements and constitute "meaningful" engagement, consultation must occur immediately, be carried on continuously, and should never be a mere formality.

The TTAG is comprised of the leaders in Indian Country healthcare with various fields of subject matter expertise, and each leader is chosen to represent the interests of Tribal healthcare programs nationwide. Timely and meaningful consultation with the TTAG is of the utmost importance as the TTAG is the established Tribal intermediary for all Tribal issues within Medicare and Medicaid programs. However, CMS appears to have completely ignored or disregarded the TTAG's detailed comments submitted in response to CMS' Request for Information last year. Our response detailed the threat these proposed standards would pose to Tribal LTC facilities and patient care overall and underlined the need for CMS to attend to the following facts of the healthcare system in Indian Country at large:

- "[W]e would like to remind CMS of the unique nature of the Indian healthcare system and the additional challenges related to the rurality of many Tribal facilities that could complicate their compliance with this rule."
- "Indian Country faces additional challenges to recruitment and retention, such as limited housing, financial resources, and training capabilities."

It is deeply concerning that CMS failed to even refer to the Indian Healthcare system in the NPRM, referring to Tribal governments only *once* as part of the recitation of the law CMS is required to follow,<sup>3</sup> and *once* in a pro forma statement that the proposed rule meets the requirements of the Unfunded Mandates Reform Act (UMRA) because it would not impose any requirements on Tribal governments.<sup>4</sup> As discussed in greater detail below, this is simply a false statement. The rule imposes a significant unfunded mandate on Tribal governments. Though the proposed rule does address some of the challenges of rural healthcare facilities, it does not recognize that some areas of Indian Country have no housing to shelter additional healthcare professionals, have impassable roads leading to healthcare facilities, and have had healthcare professional shortages for *decades*.

## III. Cost of Complying with the Proposed Rule

Aside from alerting CMS to the fact that it *must consider* the Indian healthcare system in the rulemaking process, the TTAG also articulated *specific financial burdens* the proposed rule would likely impose or exacerbate (or both):

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<sup>3</sup> 88 Fed. Reg. 61399.

<sup>4</sup> Public Law 104-4—MAR. 22, 1995.

- “Chronic underfunding of the Indian health system has contributed to significant vacancy rates for clinical care providers. The pandemic has further strained our healthcare system and has significantly impacted the workforce in many rural and underserved communities, which often include American Indian and Alaska Native (AI/AN) reservations and communities. Unfortunately, the Indian health system faces considerable challenges to overcome its long-standing struggle to fill vacancies despite our continued efforts to recruit and retain providers in underserved areas.”

The TTAG also provided comments on the specific economic challenges presented by a nationwide nursing professional workforce shortage.

- “The ongoing physician workforce shortage has disproportionately impacted the ability of AI/ANs to access quality healthcare. Health systems all over the country, including those operated by the IHS, Tribes, and Tribal organizations, are in desperate need of additional providers. We encourage CMS to continue to develop ways to increase the recruitment and retention of providers – such as RNs – in Indian Country.”

Currently, the reported average salary for an RN is already over \$77,600 yearly.<sup>5</sup> The nationwide shortage has driven up demand and forced compensation packages for an RN even further out of reach of Tribal healthcare facilities.

This proposed rule threatens the complete collapse of Tribal LTC facilities. The staffing requirements will apply as a condition of provider participation and reimbursements in the Medicare and Medicaid programs. A Tribe’s inability to comply with the proposed requirements could result in a CMS determination of noncompliance for our facilities, which would eliminate their eligibility for reimbursement under federal programs. This would worsen the gap in equity and LTC access in Indian Country where facilities are dependent on Medicare and Medicaid funds due to the lack of federally funded Tribal LTC.

#### **IV. CMS Must Exempt Tribal LTC Facilities**

CMS clearly recognizes that its proposed rule will be unworkable for many facilities, rural and Tribal alike, based on its acknowledgement of the need for a temporary exemption from the proposed staffing standards. However, CMS then outlines a temporary exemption that only applies in the following limited circumstances:

- (1) where workforce is unavailable, or the facility is at least 20 miles from another long term care facility, as determined by CMS;
- (2) the facility is making a good faith effort to hire and retain staff;
- (3) the facility provides documentation of its financial commitment to staffing; and

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<sup>5</sup> American Association of Colleges of Nursing, “Nursing Workforce Fact Sheet” (July 2023).  
<https://www.aacnnursing.org/news-data/fact-sheets/nursing-workforce-fact-sheet>.

(4) the facility has not failed to submit [data]; has not been cited for widespread insufficient staffing resultant resident actual harm or a pattern of insufficient staffing with resultant resident actual harm, as determined by CMS; and has not been cited at the “immediate jeopardy” level of severity with respect to insufficient staffing within the 12 months preceding the survey during which the facility’s non-compliance is identified.<sup>6</sup>

To be exempted, a facility must meet *all four* requirements and even then, the exemption only applies for one-year, subject to renewal by the Secretary. CMS thus imposes both a burden to first initially prove eligibility for an exemption and an additional annual requirement to prove eligibility anew.

With respect to the first element, we note that when there is a *nationwide shortage* of healthcare practitioners, it is difficult to see how CMS’ standard of “where workforce is unavailable” could be met. CMS will be required to draw a line somewhere and has articulated no workable method of fairly assessing whether the workforce is “unavailable” in a given area relative to other areas. Though the proposed rule contemplates an exemption for facilities in areas of medium (designated as 20 percent below the national average) and low (40 percent below the national average) provider-population ratios for the nursing workforce, we note that the national average is already suppressed because there is a nationwide shortage. As such, a program located in an area that is objectively short on nurse providers (as measured by whether there are enough providers to satisfy demand) may nevertheless not qualify for an exemption because the program’s needs are not as severe as elsewhere. This is an unworkable standard.

Though many of the areas in which Tribal LTC facilities are operated are known to be medically underserved and have shortages of health professionals, it seems this fact may not be sufficient to make our programs eligible for CMS’ proposed exception because CMS has made no promise to recognize HRSA-designated shortage areas or medically underserved areas. CMS should exempt all LTC facilities within an area served by an Auto-HPSA facility. Therefore, our TTAG leadership urges CMS to modify this part of the exemption to permit exemptions as long as there is not another *Tribal* LTC facility within 20 miles. Non-Tribal facilities are not an option for our Tribal Elders and vulnerable adults as this would increase isolation and decrease positive outcomes for those in residential care.

Likewise, with respect to the second element, whether a facility is “making a good faith effort to hire and retain staff” is a sliding scale for which CMS has articulated no reasonable method of reliable measurement. The “good faith effort” of a hospital in an urban area may include benefit packages and position advertisement investments that our Tribal facilities do not have the resources to offer. Moreover, this element seems to impose additional administrative burdens by requiring documentation of job listings, wages, and vacancies, to include documenting the “number and duration of the

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<sup>6</sup> 88 Fed. Reg. 61354.

vacancies and documentation of offers made.”<sup>7</sup> Our administrators and human resources are already stretched thin and when a prospective candidate falls through, they need to be able to move on, not be forced to extensively document the minutiae of their failures. This element of the exemption further entrenches health equity disparities disadvantaging Tribal communities.

The third element – that the facility demonstrate its “financial commitment to staffing” – betrays CMS’ assertion that the proposed rule does not impose new monetary burdens for Tribal governments. It is likely to exacerbate existing health inequities by punishing underfunded facilities that must expend their ephemeral financial resources to triage pressing issues and rewarding wealthy facilities with cash reserves able to support the earmarking and segregation of funds for *future, anticipated* expenses. This prong of CMS’ proposed exemption seems to suggest that our Tribal facilities should have available—but not use—funds for salaries and benefits for these positions while they wait for these positions to be filled. This requirement is unrealistic and simply inconsistent with how Tribal LTC facilities operate in the face of the non-existence of federal appropriations for long-term care in our communities.

Finally, with respect to the fourth element, we note that the underfunding of Indian Country already creates understaffing, burnout, and inadequate supplies in Tribal health facilities. We appreciate that the intent of this proposed rule is to reduce resident harm but the key indicators of what CMS defines as “immediate jeopardy” in relation to the crisis of the PHE is not applicable in Indian Country in light of the report and statistics published by the Kaiser Family Foundation’s issue brief on LTC facilities,<sup>8</sup> as most cases were related to either lack of infection control or lack of required staff vaccination – the former was induced by Tribes waiting on personal protective equipment, and the latter is nonapplicable as Tribes had very high vaccination rates once they were made available. In consideration of these measures and conditions, Tribal LTC facilities should be entitled to not only delayed implementation of a final rule but complete exemption from the proposed rule as a result of the federal government’s underfunding of Indian healthcare facilities. Tribal LTC facilities are governmental programs operating on limited budgets that are entirely dependent on federal funds. They are required by law to use all third-party resources like Medicare funding to further patient care and cannot divert them for profit or any other use.<sup>9</sup>

Tribal LTC facilities should not be forced to jump through the hoops set out by CMS’s four-pronged exemption, when the United States has a treaty and trust-based obligation to provide health care to all AI/ANs, including our most vulnerable elders. CMS must entirely exempt Tribal LTC facilities from the application of this rule. Alternatively, CMS should exempt any LTC facility located in an area served by a facility that has been

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<sup>7</sup> 88 Fed. Reg. 61428.

<sup>8</sup> *A Look at Nursing Facility Characteristics Through July 2022*. August 24, 2022. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics-through-july-2022/>.

<sup>9</sup> 25 U.S.C. § 1641(d)(2)(a).

designated by HRSA as an Auto-HPSA such as those in rural and super-rural areas near Tribal communities.

## **V. The Proposed Rule Fails to Justify the Distinction Between LPNs and RNs**

Originally, the 24/7 coverage by a licensed nurse could be satisfied by either a registered nurse (RN) or a licensed practical nurse (LPN). However, this latest proposal would require that an RN – and only an RN – satisfy the 24/7 requirement. There does not appear to be any reasoning behind this proposed change, and we therefore request that CMS elaborate on its decision, as the proposed rule lacks analysis to support such a change. Workforce shortages for RNs make the exclusion of LPNs unrealistic in rural areas, while the budgetary impact of 24-hour RN coverage is harmful to the operation of Tribal and other rural facilities, as discussed above.

The TTAG questions CMS' decision to prioritize having one singular RN on site at all times, when other priorities are possible given that the overall motivation of the rule seems to be the improvement of care provided to residents. We are concerned that this proposal – despite its intent – will do more harm than good. If the goal is truly to improve care and improve patient outcomes, the goal should be to have more nurses as opposed to one higher-level nurse available to provide care. After all, LPNs generally provide the vast majority of the direct patient care in LTC facilities, and therefore we believe that there should be more flexibility for LTC facilities in how they improve that care. For example, in areas where many Tribal nations struggle to recruit higher-level nurses, the facility should be able to offset the lack of a 24/7 on-site RNs with an increased nursing staff of other-level nurses, like LPNs, who are a core piece of the nursing workforce in any facility.

## **VI. The Proposed Rule Fails to Meet the Requirements of the UMRA**

CMS' Proposed Rule states that the new staffing standards “will not impose new requirements for State, local, or tribal governments.”<sup>10</sup> This is a demonstrably false statement. The authors of the proposed rule seem to be unaware of the fact that Tribal governments operate LTC facilities, and so simply presumed, incorrectly, that the new standards would not impact Tribal governments.

But CMS understands Tribes operate LTC facilities. In March of this year, CMS issued a guide to Tribal LTC facilities, specifically cataloguing all the Tribally operated nursing home and assisted living facilities.<sup>11</sup> CMS is also aware of the importance of Medicare and Medicaid funding for Tribal LTC facilities. Medicaid is the primary funder for all long-term services and supports,<sup>12</sup> and, as the Kaiser Family Foundation reported,

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<sup>10</sup> 88 Fed. Reg. 61426.

<sup>11</sup> Centers for Medicare & Medicaid Services, Tribal Nursing Home & Assisted Living Facility Directory (Mar. 2023) <https://www.cms.gov/files/document/tribal-nursing-home-assisted-living-facility-directory-2023.pdf>.

<sup>12</sup> CMS, Who Pays for LTSS? <https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-financing/who-pays-ltss>.



“Medicaid revenues can make the difference between a financially viable hospital or health clinic and a facility that must reduce the services it offers or close altogether.”<sup>13</sup>

To the extent CMS intended for its “no new requirements” statement to mean that the cumulative impact to state, local, and Tribal governments imposed by the proposed rule would not surpass the \$100 million threshold for the UMRA analysis, then CMS needs to demonstrate how it reached that result. If it cannot do so, it must either withdraw the proposed rule, or provide funding to Tribal LTC facilities so that any promulgated rule would not impose an unfunded mandate on Tribal governments.

### **Conclusion**

Though the TTAG leadership supports the intentions of CMS and the Administration in seeking to improve long-term care nationwide, this proposed rule is disastrous for Indian Country. We urge you to add clarifying language that fully exempts Tribally operated facilities from the proposed minimum staffing standards.

Sincerely,



W. Ron Allen, CMS TTAG Chair  
Jamestown S’Klallam Tribe, Chairman/CEO

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<sup>13</sup> Kaiser Family Foundation, Native Americans and Medicaid: Coverage and Financing Issues  
<https://www.kff.org/medicaid/native-americans-and-medicaid-coverage-and-financing/>.