**Comments on Proposed Rule #23P044 "Residential Care Home and Assisted Living Residence Licensing Regulations" as Presented to the Legislative Committee on Administrative Rules**

*Submitted Electronically by the Vermont Health Care Association - September 3rd, 2024*

The Vermont Health Care Association (VHCA) is concerned that the rulemaking process for the proposed Residential Care Home and Assisted Living Residence Licensing Rule failed to consider necessary information ahead of the final draft. Before any regulation can be effective, it needs to be clearly understood by the impacted stakeholders and constructed in a way to facilitate broad implementation. We do not believe this proposed rule reaches that standard.

In our initial comments to LCAR, VHCA highlighted two examples of areas where the rulemaking process should have supported feasible implementation but failed to do so. Our position on these two issues has not changed. In summary:

> Without a robust economic impact review in the early stages of this rule's development, we have limited information about the financial implications of the rule, potential for subsequent impact on access to services, or ways to mitigate negative effects on access. VHCA's stance remains that there will be significant challenges in implementation that will result in lost access, disproportionately affecting Vermonters who rely on Medicaid (ERC) as a payor for RCH Level III care. There is additionally no system in place for monitoring these issues. During the August stakeholder input, VHCA offered a set of potential next steps for monitoring but did not resolve the underlying disagreements.
>
> The decades-long gap in updating from the last iteration of licensure rules has led to misalignment with other related rule sets, resulting in confusion around professional nursing standards and activities. The Department of Disabilities, Aging, and Independent Living (DAIL) has determined that the solution should be incorporating current professional standards for nurses into the facility licensing regulations. While the Board of Nursing agrees that DAIL has the authority to adopt this structure (as noted in the rule packet), that is not a response to VHCA's underlying position that DAIL's approach creates confusion, exacerbates current workforce challenges, and sets us up for future regulatory misalignment and operational difficulties. The preferable approach is to offer any necessary clarification on nursing roles through education and sub-regulatory guidance.

The proposed rule has not been designed in a way that will achieve the state's goals for quality in long-term care. The result is a risk of significant harm to the public interest and our health care system during implementation. Respectful engagement with providers during the rulemaking process could have avoided this outcome. While we appreciate DAIL's efforts to meet following the initial LCAR review, we disagree with their representation of that discussion and do not believe that two meetings can replace over a year of stakeholder process failures. For this reason, VHCA maintains our opposition to adopting the proposed Residential Care Home and Assisted Living Residence Licensing Rule.

Sincerely,
Helen Labun
Executive Director | Vermont Health Care Association

**Summary of VHCA Concerns Regarding Stakeholder Engagement**

The Vermont Health Care Association (VHCA) is concerned that the rulemaking process for the proposed Residential Care Home and Assisted Living Residence Licensing Rule failed to consider necessary information in designing the standards proposed.

In May, 2023, the Department of Disabilities, Aging, and Independent Living (DAIL) circulated a preliminary draft of updates to their licensing rules for Residential Care Homes (RC) and Assisted Living Residences (AL). The regulations in place at the time were more than 20 years old, and there is no dispute that the regulations needed to be brought up to date. However, VHCA had difficulty providing an effective review of the draft due to unclear language, unclear source documents, and integration of multiple other areas of regulatory authority. Without the necessary references or context, our legal counsel was uncomfortable providing a professional opinion and VHCA anticipated that other subject matter experts would encounter similar challenges. We provided notes on the confusion and requested a meeting. Those early notes are included as an appendix.

To meet the deadline for a draft review within the constraints of the information available, VHCA compiled a line-by-line review of provider member comments for consideration, including input from a working group of 15 facility-based reviewers. Few of those comments were incorporated into the posted draft.

When DAIL posted the official proposed rule for public comment in 2023, officials asserted in public statements and in the written introduction to the rules, that any long-term care providers who were not already in compliance with the proposed rule set were providing substandard quality of care. This framing came at a time when frequency of facility inspections had increased dramatically – almost an order of magnitude greater than its recent low point during the public health emergency. The percentage of surveys resulting in citations also rose steeply and the number of citations per visit more than doubled. Members reported that they felt they were being cited under a set of rules they had never seen. Citations had become frequent in areas that had not received attention before and sometimes without clear lines of connection to official guidance. As an example, food services staff struggled with expectations that appeared based on food manufacturing rules. DAIL instituted new systems for educating administrators and updating them on emerging concerns from surveyors. Nonetheless, the combination of confusion, increased citations, and an official stance that any providers with concerns about the new rules offered low quality care produced a chilling effect on providers willing to voice concerns about the rule content.

Still without the guidance or clarifications previously requested, and in a difficult environment for connecting providers with the state for feedback, VHCA provided a summary of concerns as our public comment.

The final rule packet filed with LCAR again failed to respond to most of our concerns. A crosswalk of our public comments and where we felt no response had been given in the rule filing is included as an appendix.

VHCA did not have the necessary information to engage with the state following the initial LCAR session. We appreciate DAIL's effort to offer stakeholder sessions ahead of the second LCAR hearing. We also appreciate the effort to re-review our public comments. However, we did not have time to approach our concerns thoughtfully. We disagree with the state's representation of stakeholder feedback on VHCA's two broad areas of concern, economic impact and clarification of nursing roles and activities. We have provided details on our actual position below.

Regulations cannot simply represent a theoretical framework developed behind closed doors. They need to be a framework that providers understand, know how to implement, and can rely on in future years. This concern is not about reducing quality standards, it is about the practical steps in meeting those standards and the role of the underlying regulatory language as the first of those steps. By avoiding meaningful engagement with the providers who will be implementing these rules, the state is setting the long-term care sector up for confusion, delays in reaching compliance, economic disruption, and the potential loss of access to needed services. VHCA cannot endorse this process or the resulting document.

**Economic Impact Summary**

VHCA has raised concerns about the state's approach to an economic impact review of their proposed updates to facility regulations beginning with the draft proposal in May, 2023, again in stakeholder comments in December 2023, and finally in a dedicated memo in January 2024 (also submitted to LCAR in July, 2024).

In the stakeholder conversations after the July LCAR session, we discussed the need to move forward and VHCA's concerns that a solution for the economic impact issue be resolved *before* January 1, 2025. We did not want the risk of a delay in addressing the concern, because any monitoring of the regulations' impacts would require initiation before the rule was finalized. We also recognize that the state has the authority to implement rules they feel are critical to the safety of vulnerable adults, even in the absence of that economic review.

VHCA prepared notes summarizing what we currently know about the potential for economic impact, the limits of that knowledge in the absence of a full review, and possible next steps. Those notes are included as an appendix.

We were not aware of how our notes would be used in the final rule packet. Our stance has not changed. We acknowledge the limits of the information available due to the lack of a robust economic impact review (which had been the focus of our initial stakeholder feedback). We do not

believe that lack of necessary information reduces the likelihood of significant economic impact, it only means that we cannot provide additional details around that impact. Nor do we believe that VHCA's preliminary review, based on broad provider feedback and operational experience, was inferior to the state's internal ranking of potential impacts. VHCA's stance remains that the state failed to adequately review and plan for the feasibility of implementation (including the economic feasibility), that there will be significant challenges, and that these challenges will result in lost access, disproportionately affecting Vermonters who rely on ERC as a payor for RCH Level III care.

The only item that has changed in the VHCA position is an acknowledgement of the constraints in the current timeline and proposal of partnering with Department of Vermont Health Access (DVHA) to move forward. Having discussed with DAIL the challenges in this strategy, we are concerned that our proposal cannot meet the needs of the current timeline for this rule taking effect.

**Nursing Scope of Practice**

VHCA has presented concerns regarding the use of facility licensure rules to reflect nursing scope of practice and professional regulations. This approach creates confusion and will lead to disconnects over time as standards evolved and are updated on different schedules. We object to the idea that a change in professional standards for nurses should result in a need to reopen facility licensure regulations. Even if that were to be an acceptable premise, it would still create regulatory disconnects during the lag time in updates. We believe the reasonable approach is to provide any additional education that DAIL deems necessary for ensuring compliance with nursing standards through sub-regulatory guidance, not within the licensure rules.

VHCA proposed a three-step approach to reviewing this concern:

1. Cataloging the places in the proposed facility regulations where the issue appeared.
2. Reviewing the proposed rules with the Board of Nursing to ensure they matched DAIL's stated intent of reflecting current standards, not imposing new ones.
3. Reviewing, in detail, the practical implications of writing nursing professional rules into the facility regulations and whether the convenience of clarification today would create greater problems down the road.

To facilitate this conversation, VHCA prepared a memo offering a starting list of where we have concerns with the structure of the proposed facility rules and a starting list of questions to consider around practicality. That memo is attached as an appendix.

VHCA was not permitted to attend the initial conversation between DAIL and the Board of Nursing to present the relevant issues. We are concerned about how our input has been interpreted in the final rule packet. The Board of Nursing has indicated to DAIL that the proposed rules do not conflict with the scope of practice or delegation defined under their authority, but that does not mean that

the rules fail to add extra restrictions. In fact, the stakeholder discussion has suggested that the proposed rule *does* add new restrictions on delegation of tasks and through incorporating rules connected to certain payers into licensing for all facilities. Nor does the Board of Nursing response that DAIL remains within their authority for the credentials required in regulated facilities mean that this approach is the preferred option for offering clarification, or that they have worked with DAIL / DLP and other stakeholders to develop the best option.

While DAIL has responded to VHCA's notes highlighting areas of confusion around nursing rules, their response primarily re-states that there is confusion among providers. We find that answer to be non-responsive as it simply confirms the original theme. The notes from VHCA also provided examples of questions raised by a decision to offer nursing role clarification through facility licensure rules as compared to any of the many other means of provider education. Some of these examples have received a shorthand response in the final rule packet, but again we do not believe this addresses the underlying request to fully review the implications of their proposed structure.

Finally, we are concerned about the state's focus on matching how systems work *today* – that is only a first step. A root cause of provider confusion is that rules and systems changed over the years and the licensing regulations did not. They will continue to change. DAIL has outlined how the structure of the regulations matches how things work today - for example, aligning with the most recent nursing scope of practice update or the shift away from Board of Nursing communication through position statements. DAIL has failed to build a system that avoids bringing the sector back into challenges with misalignment and provider confusion.

**Conclusion**

VHCA first raised the issue of appropriate means for facility education around nursing practice in May of 2023. We detailed where providers had differing interpretations of the current guidance. If conversations about nursing activities had been undertaken when we began our request over a year ago, those facilities previously confused about the nursing rules could be well on the path towards compliance by now. Vermont's long term care sector is experiencing unprecedented nursing workforce shortages. Our providers would have benefited greatly from support in reaching compliance as soon as the disconnects were first identified. We are concerned about these delays and the impact on providers who have been attempting, in good faith, to deliver high quality care.

Similar examples of missed opportunities appear in the economic impact review. As noted in earlier testimony, VHCA's preliminary assessment of economic impact suggested that some areas of concern were administrative in nature, others related to implementation timing, and some could have been resolved through better alignment of rules for providers that combine multiple levels of care. These problems could have been resolved without changing DAIL's underlying regulatory goals. Plus, early resolution on areas of confusion around interpreting the proposed regulations

would have allowed for reasonable business planning by providers who anticipate financial stress from the new regulations. We now have very little time to prepare for the changes.

There is no opportunity to go back in time to change the process that has occurred, and VHCA recognizes that updates to AL / RC licensing regulations are long overdue. However, we cannot support adoption of a poorly designed rule.

**APPENDIX: <u>Regulatory Alignment & Request for Clarification - RCH / ALR Guidance:</u>**

Summary of Rules Workgroup Questions regarding regulatory alignment, definitions, source documents for reference.

*As noted in the preceding comments, VHCA provided a line edit review of the draft licensing regulations in May, 2023. However, the group working on that review had questions and need for clarifications, which we pulled out into notes by section.*

What rules (if any) are traced back to ERC payments / enrollment in Medicaid? Are there CMS rules for accessing matching funds that support a CMS-defined "nursing home level of care"? And similarly for ACCS payment source? And are ERC-tied rules being applied to facilities that only accept ACCS the way this is written? Applied to private-pay facilities?

- What part of the **Nursing Home Level of Care** section (XII) is explained by the payment rules? (In other words, what are the specific provider choices that trigger the stricter regulations and if a provider wanted to disentangle from some of those requirements, what would they change to be within a lower level of obligation).
- These proposed guidelines also appear to apply stricter standards across an entire facility if a very small number of residents have a variance for a higher level of skilled care – is that a federal requirement or a state level choice?

The new definitions in 2.2 - are these standard? What is the source document?

**Nursing Tasks & Delegation:** Overall recommendation will be to replace DLP reference to "registered nurse" with references to professional standards and scope of practice as determined by the Board of Nursing. Also match delegation to be no more restrictive than nursing guidance. Splitting authority between DAIL and BoN is a significant concern.

Specific questions outlined in formal comments around clinical best practice and timely use of medications needed for treatment (for example, UTI & antibiotics).

**Ownership Definition (2.2** page 5 and subsequent references 4.1.g, 4.4.d, 4.9.b (assuming debts), 4.10, 4.13.e ) - What is this based on and can DLP really go that far into accessing individuals' financial information? In particular, the clause about "Any person affiliated with a corporation, partnership, or association with 10% ownership"? Is this a problem in terminology or a difference in content from other financial rules?

**Financial Stability** (ownership rules above, plus 4.16.b(6)): How does the financial assessment of individuals connected with a facility fall within DLP authority? Is the appropriate expertise available for review? What is the role of DVHA in the financial components?

**Uniform Consumer Disclosure & Admission Agreements** (5.2)**:** Is there a common understanding of what uniform consumer disclosure covers and how that differs from admission agreements? Is there a way to help providers navigate and will the DLP-provided form impose new requirements by reference?

**Level of Nutrition Services** (primarily Section 7): Understanding is that these are meant to be an abridged version of ServSafe (ie ServSafe training would cover more than is required by DLP), and underlying guidance is USDA (food safety and basic nutrition) and CMS (therapeutic meals)? We believe use of therapeutic meals in recent years has expanded to cover some services that would be considered SNF-level (e.g. SLP?). Reviewing recent survey results suggests that surveyors are imposing a higher standard than what is expressed in this intent?

**Fire Safety** (primarily 9.11): Removing Division of Fire Safety inspection parameters from DLP guidance text and incorporating by reference.

**Background Checks** (5.11.e): Many staff positions are covered by OPR rules - can those be by reference and aligned with others? Note also that OPR is managing process of getting through current backlog with VCIC.

**Reporting Untimely Deaths** (5.12.c(2)): This is already covered by Attorney General's Office, Medical Examiner, State Registrar

**Adult Protective Services** (5.12.c(5)): Can these be incorporated by reference, not by cut & paste? Note the regulations were modernized in this legislative session.

**Emergency Planning & Vermont Health Emergency Preparedness Center** (5.13.b, food supplies): Defer preparedness for PPE, or food supplies, to emergency planning structures?

**Nursing Home Level of Care** (Section XII): What is happening with this definition – where did it come from? And the undisclosed assessment tool?

Quality Improvement (12.8) - Is this adding Nursing Home QI requirements to RCH / ALR and if it is, could it be by reference to existing federal guidance with exceptions that take away components instead of by describing a separate structure?

**Rules Addressing Care Transitions**: Care transitions, including levels of LTC facility, hospital transitions, and role of home services, may require a larger policy conversation to understand the goals across continuum of care and how these proposed rules fit in.

**APPENDIX: Public Comments & State Response**

Comments on Proposed Rule #23P044 "Residential Care Home and Assisted Living Residence Licensing Regulations"

*Submitted Electronically by the Vermont Health Care Association Red text reflects how state responded to concerns listed in their rule packet submitted to LCAR for July 25th, 2024, committee meeting.*

Thank you for the opportunity to comment on the proposed rule #23P044 "Residential Care Home and Assisted Living Residence Licensing Regulations" submitted by the Department of Disabilities, Aging, and Independent Living (DAIL) at the Agency of Human Services (AHS).

The Vermont Health Care Association (VHCA) is a statewide trade association representing Long Term Care residential facilities, including Skilled Nursing Facilities, Assisted Living Residences, and Residential Care Homes. We thank the state of Vermont and Division of Licensing and Protection for their ongoing work with us and our members as they seek to update the licensing regulations.

In the spring of 2023, VHCA collected input from across our membership on an early draft of these proposed regulations and convened a regulatory review committee to provide a detailed review of the proposal. Our initial review included a compilation of proposed line edits for both clarity and content, as well as reflecting an overall concern from members that the rules as written could not be reasonably implemented. We requested further conversations with the state that could bring together other divisions of AHS, including reimbursement, to review the larger operational and financial concerns raised by providers. We recognize that the state considered our preliminary input and elected to keep their original proposed timeline for finalizing the rule without an economic impact review or further stakeholder discussion on implementation concerns. State notes willingness to work with stakeholders on a schedule for enforcement phase-in, VHCA does not see this as equivalent to the discussion / assessment requested here and in previous comments (May 2023; January 2024).

VHCA members have re-reviewed the final proposed licensing regulation changes. Our opinion remains that they will have a significant financial and operational impact on Residential Care Homes. We believe the impact is significant enough to potentially reduce services available to Vermonters in need of enhanced residential care. Our position is that this impact should be reviewed before finalizing the proposed regulatory changes. The following comments outline how we reached that conclusion.

**Summary Comment:**

The Vermont Health Care Association (VHCA) agrees with the conclusion that current regulations governing assisted living residences (ALR) and residential care homes (RCH) have fallen out of date and require revisions to match current needs of ensuring the quality of residential long-term care in our state. However, we believe the significant changes outlined in this proposal should have received a close review for economic impact, feasibility of implementation (including alignment with other related regulations), and a reimbursement plan that would preserve access to services for Medicaid beneficiaries. We also have concerns about the timing of changes that increase workforce requirements

at a time when our providers are still struggling to move beyond the severe shortages experienced during, and immediately following, the COVID-19 public health emergency and preparing for the potential of CMS staffing requirements in nursing facilities that will reduce RN availability even further. Our overall recommendation is to pause consideration of these updated guidelines until additional work on what is required for successful implementation has been completed. The first recommendation for a pause to develop an implementation strategy was offered in response to the draft proposal circulated in May, 2023. VHCA is concerned that in more than a year since that time, there has been no substantive collaborative planning around feasible implementation. Furthermore, without an initial impact review or baseline assessment of ALR/RCH capacity for Medicaid beneficiaries, it will be difficult for the state to effectively track potential negative impact on care access with the new rules. See details here.

**General Member Feedback on Transitioning to New Rule Set:**

State notes in their cover letter:

> ". . .the Choices for Care (CFC) and Enhanced Residential Care (ERC) programs have placed hundreds of nursing home level of care residents into these homes. Roughly half of our RCHs and ALRs are ERC providers. The current Regulations do not provide the protections needed for a population that has increased and complex care needs or the guidance to the managers of these homes in how to provide safe care to residents who need nursing home level of care."

Based on the description of state goals, the newly added Section XII, and changes to requirements for level of Registered Nurse care in Residential Care Homes, members anticipate a need to transition some residents to higher level of care in nursing facilities and to adjust admissions policy. VHCA notes that this defeats the initial purpose of the ERC structure as supporting an alternative to nursing homes. From the perspective of Skilled Nursing Facilities, a combination of their small bed size and anticipated changes to calculating case mix index under new CMS methodology, means that accepting even a small number of low acuity residents can significantly impact their Medicaid rates. What does the state anticipate for shifts in residential placement and how will these be managed? See below comment on economic impact analysis, which might have included these considerations, had it been performed.

State has found that:

> "The rules are in line with safe standards of practice, so there is no anticipated economic impact if homes are currently operating to provide a high quality of care."

Residential Care Homes anticipate a significant economic impact, particular concerns include:

- Change in use of Registered Nurses where previously LPNs have been utilized – this includes in task delegation, medication management, admissions review, and direct care training.
- Change in staffing patterns to accommodate guidance around medication management so that residents do not experience delays in care if a new medication is added – example provided was antibiotics prescription.

- Change in staffing patterns to accommodate new training requirements for any staff with direct resident interactions before they can begin work, including temporary staff who receive training immediately prior to hire and staff with significant experience and training.
- Expansion of non-clinical services, especially around case management and specialized food preparation.
- Change to budgeting structure / calendar to accommodate the 90-day lag period on implementing rate changes.

The rate review published by the state in 2023 found that Enhanced Residential Care service payment rates had fallen up to 60% below the cost of service delivery. The rates were increased by 4% for state fiscal year 2024, but this did not close the existing gap, will not cover a significant increase in cost, and also does not include a mechanism for regular rate increases. On top of those concerns, the nursing workforce shortages currently present in the state may mean the required staffing is simply unavailable at the levels described. What does the state anticipate for implementation strategy, funding, and workforce pipeline expansion to allow for these changes? State notes in response to general public comment that the regulatory agency overseeing licensure rules focuses only enhancing resident safety and care quality. VHCA would argue that rules must either be feasible for current providers to implement, or there should be a plan for maintaining adequate capacity with changes in operations / providers made in response to the new regulations. Otherwise, the proposed regulations become a wish list and fail to meet the state's responsibility to maintain access to, or continuity of, appropriate care.

State notes in their cover letter:

> "Ownership of the homes has also shifted from local to, at times, large corporations that operate in many states with complex business and ownership structures."

VHCA recognizes the importance of ownership transparency in the residential long term care sector. However, we would like more clarity on how the updated ownership definitions and obligations impose new burdens beyond disclosure on individuals participating in the ALR / RCH sector. We note that the requirements around accepting responsibility for all debts and obligations (4.4.d), the allowance of only 5 business days to provide any information requested by the state, and the low barrier to withdrawing licensure at any point for financial instability (in a post-pandemic world with high levels of instability) combined with the new definition may have significant financial implications. We are particularly concerned about whether this takes value out of current ownership should it become impractical to sell residences to new owners. The ownership / transfer of ownership barriers remain unaddressed.

The position of VHCA is that these proposed rule changes have the potential for a significant economic impact on the long-term care sector and should not have been posted without a full economic impact assessment. See also separate survey of members to quantify extent of concerns. State responds to another comment on cost of services with the observation that DVHA sets Medicaid reimbursement; VHCA distinguishes between specific reimbursement calculations for a payor and the required economic impact assessment for feasibility of new administrative rules. VHCA comments deal primarily with the latter concern.

The following notes divide the rules as proposed into different areas of concern for implementation to provide further detail on the concerns raised above.

**Registered Nurse Requirements:**

VHCA members use Licensed Practical Nurses as key leaders in their care teams, and the previous regulations emphasized services from *licensed* nurses but not the specific licensure level of Registered Nurse. Providers instead relied on scope of practice guidance to determine what activities required higher licensure levels. The proposed updates to the regulations create a new framework for understanding the role of LPNs. VHCA still questions what the state sees as the advantage of writing guidance meant to reflect Board of Nursing licensure requirements directly into licensing regulations. A structure of referencing the licensing standards and offering additional guidance where needed to support interpretation would be a clearer approach. This structure would also avoid future confusion should the BoN standards change. Our position remains that the rules as written establish conflicting lines of authority on scope of practice. Education and clarification is likely needed but does not belong in facility licensure rules.

Examples of where this concern appears include:

Guidance on patient assessment at admission and annually (Section 5.7). Response to public comment: State chose not to clarify interpretation of how a RN would perform admission review and whether it is a new, in-person assessment performed directly by the RN vs. a review of assessment materials.

Duties for each resident requiring nursing overview, administration of medication, or nursing care (Section 5.9) and transferability of RN delegation (5.9.d). State response to other public comments notes that clarification will be offered during training and additional guidance, but does not respond to overall concern regarding incorporating BoN / licensure standards in text vs. by reference, and subsequent potential for confusion about line of authority.

Duties for handling Medication Management including assessment delegation of tasks (Section 5.10).

VHCA members request an option for staff who have been trained in administering a medication to administer that medication when it is newly prescribed to a resident – for example, antibiotics to treat a urinary tract infection – to remove the potential for delays in treatment. VHCA notes that the BON memo on nursing delegation allows the state to create exceptions in residential facilities for these types of situations, and so we do not believe that the response to comments fully answers this question. We still wish to have an answer for why the state has chosen not to create options for timely administration of low-risk medications?

~~Training requirements added for direct care and description of where direct care skills training by an RN, but not an LPN, can count towards requirements (Section 5.11 / 5.11.d~~). Addressed in response to public comments, this clause removed.

New section created to define "Nursing Home Level of Care" including on-site RN presence and RN serving on a quality improvement committee (Section 12). VHCA will look more closely at all sections that trigger greater regulatory obligations to provide members with information to understand options for adjusting their services / admissions policies to best match their capacity and funding.

**Other Staff Requirements:**

Training requirements in the previous guidelines included annual requirements, allowing providers flexibility to adjust the timing of training to reflect employees' previous experience and also situations such as use of temporary staff where training is provided prior to the start of a short-term contract. The updated guidance removes this flexibility by adding an "upon hire" clause to training requirements.

12 hours of training must be provided on hire and each year for each staff person providing direct care; adds three more components to the required training (5.11.c). Concerns about inflexibility of "on-hire" direction is not addressed.

For Special Units, adds training requirements (8 hours) prior to staff working independently with residents and 2 hours of dementia-specific training per year (Section 5.6). Concerns about inflexibility are not addressed, and range of staff included in this requirement is expanded from direct care to all staff who "regularly interact" with residents.

VHCA members are also unsure on how to implement the new background check requirements, if the staff related requirements are different from new requirements already implemented by OPR, and how they are meant to implement the background check requirements including for personal staff brought in by residents (5.11.e). Concern received no response.

**Expanded Service Requirements:**

VHCA members have concerns about new services that may be required under the updated regulations and lack of a complementary review of the cost / available reimbursement for these services. In response to another comment, state notes that concerns about reimbursement are relevant to DVHA and that the rules as outlined are immediately required to protect the safety of residents. VHCA does not agree that the rules listed here are urgent changes for basic resident safety or that DVHA authority over reimbursement excuses DAIL licensure regulations from an economic impact review. Examples include:

Case management for homes certified for ACCS services is newly defined as: "assisting residents in gaining access to needed medical, social and other services, coordination of activities required

in the resident's plan of care, coordination of available community services, and discharge planning. Residents shall be informed upon admission, and any time there is a change, of the name of the staff person responsible for case management." (5.2.c(7)). Concern received no response.

Transportation services changed from "not to exceed" 4 trips per month to "4 or more" trips per month (5.16.b) State clarifies that facilities may cap the trips at 4 in admissions agreements.

Providing therapeutic diets is clarified to include mechanically-altered diets (7.1.a).
VHCA members note that the definitions of meals as part of clinical treatment have changed significantly since the rules were first written, and they had understood some levels of therapeutic meals to rise to a SNF level of care. Concern received no response.

Residents may request an alternative meal schedule (7.1.c).

VHCA members are concerned about open-ended language around alternative food options and meal schedules, their food services are not set up to provide restaurant level flexibility. "Reasonable" added to regulations; this addresses some of the concern but not members' underlying concern about creating confusion. This may be addressed in implementation.

~~Use of home health services limited to 30 days (reduced from 60) before a variance is required (5.9.e~~). State retains 60 days.

Requirement to convert prescription systems away from telephone communications or to take all orders using licensed nurses (5.8.d). State provides explanation in response to another comment.

**Administrative Burden:**

VHCA members have voiced concerns about administrative burden that fall into several categories. Some of the concerns are around understanding how to operationalize the rules as written, including how to interpret the language. Some concerns relate to capacity at the state and other entities to provide timely responses to providers that will allow their compliance with the rules as written – for example, members report that long delays in state response to survey results impede their ability to meet the regulatory deadlines for their own responses to state findings. Other concerns relate to timeline and reporting changes that will substantially change business operations. Examples of administrative burden concerns include:

Requirement to report unexplained absences of 2 hours to police, family, and licensing agency – decreased from 12 hours absent (5.12.c(3)). State responds to another comment by explaining that inclusion of 'unexplained' addresses the concerns about residents' rights; VHCA disagrees.

~~Rules extend time to notify residents of rate changes to 90-days from 30~~ – as changes to public payer rates may not have this lead time, and may in fact be retroactive, this creates an

administrative challenge of how to set up rate change structures to comply while also minimizing revenue loss (5.2.f). Clause returned to 30 days.

Requirement that owners and licensees respond to any DLP request for communication or information within 5 business days – an extremely short turn around time, depending on what is included in the request and how much it relies on individuals' expertise (4.13.e). Concern received no response.

Concerns regarding places where DLP regulations rewrite regulations also covered by other entities, requiring cross checking and potential misalignment as rules change. Areas of concern include definitions section, uniform consumer disclosure, background checks, adult protective services, review of financial stability, reporting untimely deaths, emergency preparedness, quality improvement programs. Concern received no response.

Repetition within the regulations and variations in terminology present challenges to interpretation and planned implementation.

> For example, the Special Units section (5.6) describes an application process that includes specific descriptions of all staff training, in-service education, and specialized training. . . then in another section requires these materials *plus* the training curricula be made available for residents and family members, implying that providers will need to review / revise all contracts with trainers on access to specific components of their training materials.

Similarly, the rules include detailed formatting instructions for posting information, reference use of forms and assessments not yet available, and terms that require clarification around consumer disclosures. Concern received no response. See also May, 2023, request for clarifications.

**Requirements for Financial Stability:**

Concerns within this category received no response

In addition to the above listed new stressors on the economics of an ALR/RCH provider, the proposed regulations add significant power to revoke or deny a license for any provider experiencing financial stress:

- 4.16.b(6) Requirement to demonstrate financial stability within 10 days of a written request to do so.
- 4.9.b State requires any prospective new owners to agree to accept responsibility for debts and obligations incurred under prior ownership.
- 4.4.d State requires license applications to show current and ongoing financial stability of proposed owners, with a very broad definition of who qualifies as an owner added to the definitions section.

As noted in the introduction, VHCA also has questions about how the changes to the state's approach to ownership may impose new liability risk on individuals investing in the long-term care sector and how this is anticipated to shape future investment. In addition to the micro-level review of the impact these new rules will have on the business models of individual facilities, we also encourage a macro-level consideration of long-term care service access in the state and anticipated trends in that access.

For final consideration, we are attaching our notes on trends in available ALR / RCH beds in Vermont, based on posted licensing data. We believe these trends map a loss in affordable services in most regions of Vermont, even as we also see losses in nursing home access and increasing demands for long-term care services from an aging population. The Vermont Health Care Association strongly recommends performing an economic impact analysis before finalizing the proposed Residential Care Home and Assisted Living Residence Licensing Regulations rule.

**APPENDIX: Notes on Economic Impact Summary Next Steps**

*Following the initial stakeholder meeting to review concerns raised in the July LCAR committee meeting, VHCA prepared the following notes summarizing a potential compromise for moving forward. Notes provided to the state on August 7, 2024.*

Economic impact summary statement from LCAR filing:

> "The rules are in line with safe standards of practice, so there is no anticipated economic impact if homes are currently operating to provide a high quality of care."

The statement can't be easily changed due to the difficulty of revising a rule filing, but to highlight the concerns that make VHCA uncomfortable with this phrasing:

- The impact statement doesn't find there is no economic impact – it only finds that the economic impact will be on homes not currently providing high quality of care. If a policy goal is to retain capacity while delivering high quality care, this could become a significant economic impact (depending on how many facilities will need to make changes and how large those changes wil be).

- If a primary concern for DLP in updating the rules is to offer clarification and education to correct widespread misinterpretation of the current standards (as stated in the rule development), then it is reasonable to expect there *will* be a broad need to change current practices.
    - It becomes difficult to assess the actual reach of the impact during public comment, as facilities will not want to raise their hands to say there is an economic impact once that statement is considered synonymous with low quality of care.

- With such a long delay since the last regulatory update, we would assume that there are some deferred costs embedded as providers catch up with incremental changes that accumulated over the decades. Even if the cost is short-term, for initial compliance and systems change, that is still an impact.

VHCA's survey of members suggested that they perceived a potential for significant economic impact. How much of that perception is an accurate interpretation of changes that the regulations will require, what exactly is meant by "significant", and which specific elements of the rule have the greatest impact would require a full economic impact review.

The most we can say is that there is a potential for upward pressure on rates attributable to the change in facility licensure regulations.

VHCA recognizes that even if a full economic impact review had shown a negative impact, that fact would not outweigh the public interest in having up-to-date licensing regulations and acceptable safety standards. We fundamentally agree with the need to implement rule changes in a timely fashion.

VHCA also recognizes that DLP is not the appropriate division to implement economic strategy for health care providers, the primary utility of a full economic impact assessment at this point in the rulemaking process would be for communication with other departments that *do* have that responsibility. We can provide those communications without a full review.

**VHCA recommended next steps**

- DAIL / DLP provides DVHA with their list of changes made in the final updated regulations; VHCA provides with our comments / information collected from members in January 2024 – we will clarify that this feedback was from the *proposed* rule, not the final rule and is only meant to offer context.

- DVHA can compare this information with the structure and results of their 2023 Rate Reimbursement study and determine if they will need to plan for another study to update the previous findings.
    - As a practical matter, the ERC rates still aren't up to the levels recommended in the *last* rate study; VHCA recognizes we don't need a new study to know there's a gap between cost and payment in SFY2026. The concern here is more around future years.

If there is rate pressure with the new rules that is greater than DAIL / DLP anticipates, we would expect that to show up in statewide patterns of Medicaid utilization, since Medicaid is the lowest rate, the least responsive to individual facility pressures, and (as noted) we know there is already a significant gap between ERC and current service costs. VHCA recommends that DAIL coordinate with DVHA to establish a better approach to monitoring shifts in capacity to take Medicaid residents, something that will pick up financial pressure *before* a facility closure or delicensing of beds.

VHCA recommends the following indicators to monitor – note that we believe these are data points already available to DVHA, we are not intending to outline *new* data collection. DVHA would be the final authority on the best indicators, these are starting suggestions:

- Total Beds Available, by facility type (DAIL / DLP)
- Geographical Distribution of Beds (DAIL / DLP)
- Provider Enrollment in ACCS / ERC (DVHA)
- Utilization of ACCS / ERC (DVHA) - The assumption here is that DVHA has the data to be able look at where they are paying per diems to AL / RC facilities and then build trends that normalize for changes in:
    - Number of overall ACCS / ERC enrollees (ideally this could account for pending applications as well, to more accurately reflect overall demand for the service coverage)
    - Number of overall licensed beds

  This would provide a general snapshot of how access to AL / RC facilities changes for individuals with Medicaid as a payer in relation to changes in overall access. VHCA recommends reporting by region in addition to statewide.
- Review of changes in payment by tier (ACCS, ERC Tier 1 – 3) - this would suggest any shifts reducing access for higher acuity patients.
    - Given that the trends in population health in general, and AL / RC residents in particular, have been identified as towards higher acuity, we could assume that a leveling off or reduction in utilization for Medicaid enrollees shows a reduction in access and not simply a trend towards better health.

The goal isn't to be precisely correct or account for every variable, it's just to have some data-based benchmarks to see if there are indications of emerging financial pressures that impact availability of care. If there are these indications, DVHA and DAIL could then jointly determine how to respond.

This proposal does not replace an economic impact assessment – however, it does get to a likely outcome of any such assessment, which is to design a monitoring system ahead of the rule implementation. This will provide timely feedback during the phase-in of the new regulations, allowing the state to take any necessary actions to maintain both care quality and care access.

**APPENDIX: Nursing Scope of Practice and Professional Standards in Licensing Rules**

*In the initial stakeholder meeting to review concerns raised in the July LCAR committee meeting, DAIL requested that VHCA provide more details on our concerns about how professional nursing standards appear in the facility licensure rules, including specific citations within the rule language. We provided the following notes on August 8th.*

VHCA is concerned about the practice of facility licensing regulations including elements that define nursing scope of practice, professional standards, or provide interpretation of professional guidelines. We agree with DLP's concern about providing education / guidance to ensure that the relevant professional standards are being met and nurses are not acting outside their scope of practice – we do not believe that these regulations are the appropriate vehicle for offering that guidance. In general, we note that inclusion of text that is informational / for educational purposes creates a rule set that is cumbersome and more liable to have internal inconsistencies. Related to the particular example of nursing guidance, our primary concerns are

- It creates confusion by establishing conflicting authorities – we would prefer education / sub-regulatory guidance that is offered in partnership with the Board of Nursing (and relevant nursing educational bodies).

- It creates logistical problems in maintaining alignment between sources of information on nursing practice. For example:
    - The time required for making administrative rule changes will inevitably lead to months of lag time before the licensing regulations are updated to match any change in another entity's rules or guidance.
    - It is unclear what would trigger a regulatory rule change – for example, if the Board of Nursing issues a memo clarifying statute or policy, and the memo's wording is out of alignment with DLP facility regulations, but the underlying nursing statute didn't change, do the facility regulations change?
    - When there is confusion around interpreting DLP regulations meant to clarify nursing rules, who resolves the confusion? DLP or the Board of Nursing?
        - And does this change the Board of Nursing's relationship to nurses when they work in an AL/RC facility versus another provider type? Will this affect how nurses view working in an AL/RC setting?
    - If there is a proposed rule change to licensing regulations to match nursing rules, does this effectively open up a chance to re-debate the nursing decision?

  VHCA anticipates that there *will* be activity around national standards and nursing practice in long-term care residential setting – for example, guidance on expanded use of virtual technologies (and improvements in those technologies) or changes in approaches

to current medications and/or guidance on new medications becoming available (GLP-1 injection, dementia treatment, etc.) - so we do not consider logistical concerns on alignment to be purely theoretical.

VHCA recognizes that providers have also raised concerns that the proposed licensing rules do not align with current nursing scope of practice rules – for the purposes of our proposed changes to the rule, we view that input as evidence of our overarching concern about the confusion that results from creating two lines of authority for interpretation. We would not consider removing those clauses from the licensing regulations to mean the matter is resolved, only that it will be resolved in a different way.

**Examples of Specific Language:**

2.2 "Delegation of nursing tasks" means the formal process approved by the Vermont Board of Nursing which permits professional nurses to assign nursing tasks to other Individuals. ~~as long as the registered nurse (or license practical nurse under the direction and oversight of the home's registered nurse) provides proper training, supervision oversight, and monitoring, and for which the registered nurse retains responsibility.~~

As already discussed, this change removes qualifications on the definition.

5.7.b - . . . If the home is licensed as a Level III residential care home or assisted living residence, for residents requiring nursing overview, medication administration or nursing care, the assessment must be completed by a registered nurse.

VHCA's recommendation is to replace "registered nurse" with "health care professionals with the appropriate licensure level or expertise". The reason here is not to allow lower licensure individuals to do the assessment, but instead to allow discretion for assessment to include specialists / higher licensure levels. For example, if a facility has both SNF and RCH beds and are following SNF practices where the assessment may be coordinated by an RN but include assessment by other professionals.

5.9.c For each resident requiring nursing overview, administration of medication, or nursing care, ~~the registered nurse~~ nursing staff shall, within their respective professional standards and scope of practice:

Adjusts so that the facility licensing regulations identify the activities that a facility is expected to perform (list in 5.9.c) but refers elsewhere to the scope of practice.

5.9.c (4) Provide ~~direct~~ instruction and supervision oversight to all direct care personnel regarding each resident's health care needs and nutritional needs. Delegate nursing tasks as appropriate, following the Board of Nursing's recommended practices, with adequate documentation of delegation. ~~registered nurse training and competency evaluation for each nursing task delegated to each staff member~~;

Changes made to remove form of instruction and supervision ("direct") and description of documentation from the licensing regulations to instead defer to professional standards of practice, Board of Nursing recommended practice, and any sub-regulatory guidance / education needed to clarify. Does not repeat "within professional standards and scope of practice" because that is at the top of the list.

(78) ~~Assure~~ Ensure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken and proper documentation of ongoing ~~nursing~~ [?] follow-up;

This is a clarity question – do the regulations mean to say only *nursing* follow-up, or all relevant follow-up inclusive of actions by non-nursing direct care staff?

*5.9.d ~~The Manager must ensure unlicensed staff only perform nursing tasks and medication administration under the delegation of a registered nurse currently employed by the home. Upon a change in the delegating registered nurse, the incoming registered nurse shall must follow professional standards of nursing practice regarding delegation of nursing tasks to unlicensed staff.~~*

We were unclear on the intent of this bullet point. Presumably the Manager is ultimately responsible for facility compliance with relevant regulations, including but not limited to nursing services? In which case VHCA would recommend striking for redundancy and clarity. Or, is the intent to set a more-strict rule regarding medication administration than what is recommended by the Board of Nursing? In which case VHCA would object to that intent and recommend a more involved conversation.

5.10 Medication Management

Here, we officially reach the outer limits of VHCA expertise. As this guidance covers professional standards of practice, clinical best practice, and similar standards of care that we believe are covered in other guidance documents the overall recommendation would be to refer to source documents for guidelines where available. Components of this section, such as the opening distinction between Level III and Level IV licenses or rules around medication storage, do seem germane to facility regulations. We stand by our original comments on this section

when it was circulated in draft form - we feel it requires engagement by DLP, the Board of Nursing, and Nursing Manager representatives from facilities to disentangle the pieces and create a final version that is clear to everyone involved.

> ~~12.2 If a home's registered nurse assesses a resident and determines that the resident requires nursing home level of care, the resident must be given a notice of discharge unless the home's Manager applies for, and the licensing agency grants, a level of care variance that allows the home to retain the resident. If a home's registered nurse assesses a potential resident and determines that the potential resident requires nursing home level of care, the home's Manager must apply for, and be granted, a variance prior to admitting the individual to the home.~~

Not sure what this is establishing that is different from 12.1.a and 5.7? That's why it's a strike through.

12.3

> (4) ~~The registered nurse must be available onsite at least one (1) hour per week per nursing home level of care resident.~~
> (5) ~~There must be sufficient direct care staff onsite to ensure at least two (2) hours per day of assistance with personal care, per nursing home level of care resident~~.

If facilities are conducting assessments and care planning to match the individual needs of residents, as outlined elsewhere in the regulations, then that should be establishing the appropriate staff levels. This isn't precisely a scope of practice issue, but it's a guiding documents issue – and if the individual assessment and planning isn't the guiding document then the question would be what the source of these numbers is?