significantly or uniquely affect small governments. The action imposes no enforceable duty on any state, local or Tribal governments or the private sector.

F. Executive Order 13132: Federalism

This action does not have federalism implications. It will not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government.

G. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This action does not have Tribal implications as specified in Executive Order 13175. This action responds to comments on the IFR and does not make any additional changes. Thus, Executive Order 13175 does not apply to this action.

H. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

Executive Order 13045 directs Federal agencies to include an evaluation of the health and safety effects of the planned regulation on children in Federal health and safety standards and explain why the regulation is preferable to potentially effective and reasonably feasible alternatives. This action is not subject to Executive Order 13045 because the EPA does not believe the environmental health or safety risks addressed by this action present a disproportionate risk to children.

I. Executive Order 13211: Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use

This action is not a ''significant energy action'' because it is not likely to have a significant adverse effect on the supply, distribution, or use of energy.

J. National Technology Transfer and Advancement Act (NTTAA)

This action does not involve technical standards.

K. Congressional Review Act (CRA)

This action is subject to the CRA, and the EPA will submit a rule report to each House of the Congress and to the Comptroller General of the United States. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Lee Zeldin,

Administrator.

[FR Doc. 2025–21787 Filed 12–2–25; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 483

[CMS–3442–IFC]

RIN 0938–AV25

Medicare and Medicaid Programs; Repeal of Minimum Staffing Standards for Long-Term Care Facilities

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period repeals provisions of the final rule titled ''Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting.'' This action is taken in view of changes made by by public law, which precludes HHS from implementing, administering, or enforcing certain provisions of the final rule until September 30, 2034.

DATES: These regulations are effective on February 2, 2026.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, by February 2, 2026.

ADDRESSES: In commenting, please refer to file code CMS–3442–IFC.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3442–IFC, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3442–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: The Clinical Standard Group's Long Term Care Team at *HealthandSafetyInquiries@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

In the May 10, 2024 **Federal Register** (89 FR 40876), the Centers for Medicare & Medicaid Services (CMS), published a final rule titled ''Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting'' (hereinafter referred to as 2024 Minimum Staffing final rule). This rule, among other items, established minimum staffing standards for long-term care facilities participating in Medicare and Medicaid programs. The standards were informed by data and literature available in 2022 and 2023.

On July 4, 2025, Public Law 119–21 was signed into law. Section 71111 of Public Law 119–21 prohibits CMS from implementing, administering, or enforcing the minimum staffing standards set forth in § 483.5, definitions related to staffing requirements, and § 483.35, requirements for a registered nurse (RN) to be onsite 24 hours, 7 days per week and that each facility provides a minimum of 0.55 RN, 2.45 nurse aide (NA), and 3.48 total nurse staffing hours per resident day (HPRD), for a specified time period. This legislative action effectively suspends implementation of these provisions until September 30, 2034.

II. Basis for Repeal

A. Legislative Moratorium

Section 71111 of Public Law 119–21 precludes CMS from implementing, administering, or enforcing the minimum staffing standards established in the 2024 Minimum Staffing final rule (89 FR 40876) until after September 30, 2034. This prohibition renders portions of §§ 483.5 and 483.35 unenforceable and unimplementable during the period before October 1, 2034. Congress has thus effectively suspended these provisions for that period. We believe that this prohibition warrants restoration of the previous version of the Code of Federal Regulations (CFR). Without such revisions, the regulations would lack nurse staffing standard that implements the minimum requirements for long-term care facilities set forth in sections 1819(b)(4)(C)(i) and 1919(b)(4)(C)(i) of the Act.

B. Policy Considerations

HHS and CMS are committed to protecting the health and safety of residents in long-term care facilities. Following the publication of the final rule, interested parties continue to express their concerns over the establishment of the quantitative minimum staffing standards, requiring a RN to be onsite 24 hours, 7 days per week and that each facility provides a minimum of 0.55 RN, 2.45 NA, and 3.48 total nurse staffing HPRD.

LTC facilities, particularly those within rural and tribal communities, raised significant concerns that these standards, even with a comprehensive exemption process in place, could increase the risk of facility closure, thus potentially decreasing access to healthcare. Rural and tribal communities face a specific challenge of geographic isolation, making it difficult to recruit nurses and for patients to access care.[1] LTC facilities continue to note hiring challenges due to the existing labor supply and available resources despite their best efforts to meet these requirements. The National Indian Health Board stated that the 2024 final rule would be catastrophic for keeping facilities open and meeting the trust and treaty obligations in healthcare because of the difficulty of staffing in Indian Country. Further, they noted that LTC facility closures like this in tribal communities do not just remove jobs but break cultural bonds and remove elders from their communities.

Likewise, multiple sources have described the current and projected shortages, including the International Council of Nurses (ICN) report calling for the worldwide shortage of nurses to be treated as a global health emergency. The report, titled *Recover to Rebuild: Investing in the Nursing Workforce for Health System Effectiveness*,[2] details the impact that the pandemic had on the world's nursing workforce, nurse burnout, and access to care. The National Center for Workforce Analysis (NCHWA) [3] projects nationwide nursing shortages, including a shortage of 295,800 nurses nationwide, with larger shortages of nurses in nonmetropolitan areas including rural and tribal communities. In addition, according to a *Health Workforce Analysis* published by the Health Resources and Services Administration (HRSA), authorities project just 63,720 people working as full-time RNs in 2030. Lastly, the American Association of Colleges of Nursing predicts that RN shortages will continue over the next decade and beyond, with a 13 percent deficit in the total number of RNs in nonmetropolitan areas predicted to be needed in the United States by 2037, and a 5 percent deficit of RNs predicted for metropolitan areas of the country.[4]

Furthermore, two district courts have vacated at the summary judgment stage the minimum staffing provisions related to HPRD and the 24/7 RN requirement as currently drafted and codified at 42 CFR 483.35(b)(1) and (c). First, in the summary judgement for *American Health Care Association* v. *Kennedy* (Case Nos. 24–144 and 24–171, 777 F. Supp.3d 691(N.D. Tex. 2025)) [5] (appealed June 2, 2025 to the Fifth Circuit), the court relied on the major questions doctrine in its finding that HHS exceeded its statutory authority with the minimum staffing policy changes. Second, in the summary judgement for *Kansas* v. *Kennedy* (Case No. C24–110–LTS–KEM,__F. Supp. 3d__(N.D. Iowa, June 18, 2025) [6] Interested parties should refer to the detailed order and judgement for each case for additional information.

HHS no longer believes that the current quantitative minimum staffing standards affected by the moratorium and litigation are appropriate, especially because the minimum staffing standards do not follow from the best interpretation of the relevant statute. The quantitative minimum staffing standards, as currently written, impose one-size-fits-all minimum requirements on all facilities across the country without accounting for differences in local labor supply, overall acuity of the facility's resident population, or available resources. Rural and tribal community facilities currently face significant difficulties in recruiting and retaining staff; the current quantitative minimum staffing standards could put many of these facilities at an increased risk of closure, thus potentially decreasing access to health care in these communities.

Given these policy considerations, HHS has modified its policy views with respect to the quantitative minimum staffing standards.

C. Tribal Community Considerations

In view of the policy considerations stated previously, and upon further consultation and review of certain comments, HHS and CMS believe there is an opportunity to further engage with Tribal communities. CMS received correspondence from tribal communities noting that longstanding healthcare workforce shortages across Indian Country make compliance with the LTC staffing rule impossible for many facilities and that the rule would cause closures of many LTC facilities due to limitations present in Health Provider Shortage Areas (HPSA) in rural and remote areas. In addition, the Tribal Technical Advisory Group (TTAG) is in favor of the 10-year moratorium, stating that this ''supports the continued operation of rural Tribal LTC facilities''. As noted previously, the minimum staffing standards, if implemented, may impose disproportionate burdens on facilities serving these communities, which face a distinct workforce and resource constraints. Repealing the changes made to minimum staffing

[1] Taylor, Noelle, et al. ''Promising Practices to Address Healthcare Needs Voiced by Local Native Americans.'' *DigitalCommons@USU,* 2025, *digitalcommons.usu.edu/tcjournal/vol2/iss1/4/.* Accessed September 18, 2025.

[2] Buchan, James, and Howard Catton. *RECOVER to REBUILD INVESTING in the NURSING WORKFORCE for HEALTH SYSTEM EFFECTIVENESS International Council of Nurses the Global Voice of Nursing.* 2023.

[3] McGhee, Moira. ''A Crisis by the Numbers: Nursing Shortages in 2025 by State.'' *Yahoo Finance,* Vivian Health, February 24, 2025, *finance.yahoo.com/news/crisis-numbers-nursing-shortages-2025–163000209.html?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAACgfnz8Zi44P6ei-zweMuE0reqyIi9N19l_UlZVnmeFi0iHKKbYKSrtXhK23rJ6yZQ9Ny2dDkmXAlJropGQI2grGod8aHqswrTZBa0eiYk6EEyW9usg5XEYExAWFSvEP24uxek-T5cxKAvfjFgVRWHFZDR98zsEBIafohInLbBiH.* Accessed September 5, 2025.

[4] American Association of Colleges of Nursing. ''Nursing Shortages Fact Sheet.'' American Association of Colleges of Nursing, 2024, *www.aacnnursing.org/news-data/fact-sheets/nursing-shortage.*

[5] Available at *https://caselaw.findlaw.com/court/us-dis-crt-n-d-tex-ama-div/117139174.html.*

[6] Available at *https://caselaw.findlaw.com/court/us-dis-crt-n-d-iow-ced-rap-div/117400951.html.*

standards by the rule provides an opportunity for CMS to reassess these burdens and further engage in additional dialogue with Tribal communities to better understand and address their concerns. We invite and welcome additional consultation with Tribes on the impact of the now-rescinded portions of the final rule and encourage Tribes to submit comments during the comment period for this interim final rule with comment period.

D. Agency Determination

Given the moratorium imposed by Public Law 119–21, the policy considerations discussed previously, and a desire to further engage tribal community concerns, we are repealing certain suspended provisions of §§ 483.5 and 483.35 and restoring the previous language of § 483.35, while soliciting further comment. This repeal ensures that the regulations reflect current legal authority and HHS policy, and allows for future rulemaking that incorporates new, up-to-date evidence and interested party input.

III. Provisions of the Interim Final Rule With Comment Period

This interim final rule with comment period revises the following sections of 42 CFR 483:

- In § 483.5, we are removing the definition of ''hours per resident day'' since it is only used in relation to the minimum staffing requirements in this section that this rule repeals; therefore, the definition is no longer relevant.
- In § 483.35, we are making the following changes:

++ Removing the requirements for long term care facilities to have an RN onsite 24 hours, 7 days per week and the minimum requirements for 0.55 RN, 2.45 NA, and 3.48 total nurse staffing HPRD requirements.

++ Reinstating the minimum statutory RN staffing requirement for LTC facilities to use the services of an RN for at least 8 consecutive hours a day, 7 days a week and to designate an RN to serve as the director of nursing on a full-time basis except when waived.

With converting the nurse staffing requirements at § 483.35 back to the requirements finalized in the 2016 ''Medicare and Medicaid Programs; Reform of Requirements for Long Term Care Facilities'' final rule (81 FR 68688), we are also including technical corrections to several incorrect paragraph citations that were made as part of the updates to § 483.35 in the May 2024 Minimum Staffing final rule (89 FR 40996 through 40998). We are finalizing the corrected citations as part of this interim final rule with comment period to assure accuracy and clarity. Therefore, we are making the following revisions:

++ In the introductory paragraph, we are replacing the reference to § 483.70(e) with a reference to § 483.71, where facility assessment requirements are now located.

-- In paragraph (a)(2), we are changing the cross reference from paragraph (c), Proficiency of nurse aides, to paragraph (e), Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. The requirement will now state that, except when waived under paragraph (e), a facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

-- In paragraph (f)(2), we are changing the cross reference from paragraph (d)(1) to paragraph (f)(1), which allows for the Secretary of the Department of Health and Human Services (Secretary) to waive the requirement that a skilled nursing facility provide the services of an RN for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, under certain circumstances. This requirement will now state that a waiver of the RN requirement under paragraph (f)(1) of this section is subject to annual renewal by the Secretary.

-- In paragraph (g)(2)(i), we are changing the cross reference from paragraph (e)(1) to paragraph (g)(1) the facility must post the nurse staffing data on a daily basis. This requirement will now state that the facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

IV. Good Cause for Proceeding With an Interim Final Rule With Comment Period

For the reasons described in this section, we have determined that an interim final rule with comment period is the appropriate mechanism to align regulations with current enforceable law. Although this interim final rule with comment period is effective in 60 days, comments are solicited from interested members of the public on all aspects of the interim final rule with comment period. We will consider these comments in deciding the next steps following this interim final rule with comment period.

Under the Administrative Procedure Act (APA) (5 U.S.C. 553(b)(B)) and 42 U.S.C. 1395hh(b)(2), CMS may forgo notice-and-comment rulemaking when it finds, for good cause, that such procedures are impracticable, unnecessary, or contrary to the public interest. We find that there is good cause based on the totality of the circumstances described later in this section.

The current regulations at issue here have not yet been enforced, and section 71111 of Public Law 119–21 precludes CMS from taking any further actions to administer or enforce them until September 30, 2034. Additionally, two Federal district courts have vacated portions of the final rule and there is no current reliance on these provisions by regulated entities or the public. The absence of a comment period before repeal will not cause injury to any interested person.

Moreover, maintaining regulations that are unenforceable and unimplementable for several years in the CFR is confusing and impracticable. The presence of unenforceable and unimplementable provisions during the moratorium could lead to misunderstandings regarding applicable standards, potentially causing confusion among LTC facilities, regulators, and the public. Repealing these specific provisions immediately eliminates this risk and ensures regulatory clarity. Moreover, it is impracticable to maintain these unenforceable regulations because doing so would prolong the period in which there is no specific implementing language for sections 1819(b)(4)(C)(i) and 1919(b)(4)(C)(i) of the Act to specify the level of staffing CMS views as ''sufficient'' to meet nursing needs of residents and establish consistent nationwide standards of mandatory minimum staffing levels in regulated facilities. While many States have regulations in place for minimum nursing services to LTC facility residents, those regulations vary, and do not assure consistent minimum standards across the country.

We also believe that including a comment period before repealing a regulation that can only be enforced and implemented almost a decade in the future is unnecessary. Further, the inclusion of a comment period would delay the removal of unenforceable regulations and prolong confusion and possible misapplication or misapprehension of standards, which would be contrary to public health interests served by the staffing standards, including setting a national and broadly applicable baseline. We considered delaying the repeal until after a comment period or delaying the effective date to 2034, but given the facts, context, and litigation, we concluded that doing so would perpetuate regulatory uncertainty and is not in the public interest.

While under these specific circumstances we find good cause for issuing this interim final rule with comment period prior to a public comment period, the agency is committed to considering public input. We invite comments on this interim final rule with comment period and future rulemaking. Comments received by the date specified in the **DATES** section of this interim final rule with comment period will be considered in determining whether further action is warranted.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501–3520, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This rule does not impose new information collection requirements. Instead, it revises an information collection requirement established in the 2024 Minimum Staffing final rule (89 FR 40876). In that rule, we estimated that long-term care (LTC) facilities would spend 19 hours annually reviewing and updating policies and procedures related to the nurse staffing requirement at § 483.35(a), which mandated 0.55 hours per resident day (HPRD) for registered nurses (RNs) and 2.45 HPRD for nurse aides (NAs) (89 FR 40937).

To estimate the savings from removing this burden, we apply the same methodology and data sources used in the 2024 rule. Readers can refer to the 2024 final rule's collection of information section for detailed discussion on the data sources and methodology used to estimate costs.

In the 2024 final rule, the annual baseline cost of the requirement at § 483.35(a) was estimated at $24,440,832 (89 FR 40939).

In accordance with OMB guidance document (M–25–20), we are adjusting this estimate to 2024 dollars using the Bureau of Economic Analysis' GDP deflator (National Income and Product Accounts Table 1.1.9).[7] [8] We also apply a 2.31 percent annual increase in real wage rates starting in 2025, consistent with the final rule. As shown in Table 1, we estimate that removing this requirement will result in total savings of $315,672,322 over 10 years, or annualized savings of $31,567,232.

TABLE 1—SAVINGS FROM REMOVAL OF 0.55 HPRD FOR RNS AND 2.45 HPRD FOR NAS INFORMATION COLLECTION REQUIREMENTS

Year	Calendar year	Savings
Year 1	2025	$28,423,085
Year 2	2026	29,079,658
Year 3	2027	29,751,398
Year 4	2028	30,438,656
Year 5	2029	31,141,789
Year 6	2030	31,861,164
Year 7	2031	32,597,157
Year 8	2032	33,350,151
Year 9	2033	34,120,540
Year 10	2034	34,908,724
10-Year Total Savings	.....	315,672,322

VI. Regulatory Impact Analysis

A. Statement of Need

This interim final rule with comment period is necessary to align the CFR with the statutory moratorium imposed by section 71111 of Public Law 119–21, which prohibits CMS from implementing, administering, or enforcing the minimum staffing standards currently in place at §§ 483.5 and 483.35 until September 30, 2034. In addition, following the finalization of these staffing standards, interested parties expressed significant concerns about the rule's impact. In particular, LTC facilities within rural and tribal communities indicated that the rule's requirements could increase the risk of facility closure. As such, we are rescinding the requirements that facilities have 24/7 RN coverage and that they provide a minimum of 0.55 RN, 2.45 NA, and 3.48 total nurse HPRD.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Act; and section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety,

[7] Office of Management and Budget. Guidance Implementing Section 3 of Executive Order 14192, Titled ''Unleashing Prosperity Through Deregulation''. *https://www.whitehouse.gov/wp-content/uploads/2025/02/M-25-20-Guidance-Implementing-Section-3-of-Executive-Order-14192-Titled-Unleashing-Prosperity-Through-Deregulation.pdf* (Accessed August 18, 2025).

[8] Bureau of Economic Analysis. ''National Income and Product Accounts.'' *https://apps.bea.gov/iTable/?reqid=19&step=3&isuri=1&1921=survey&1903=13#eyJhcHBpZCI6MTksInN0ZXBzIjpbMSwyLDMsM10sImRhdGEiOltbIk5JUEFfVGFibGVfTGlzdCIsIjEzIl0sWyJDYXRlZ29yaWVzIiwiU3VydmV5Il0sWyJGaXJzdF9ZZWFyIiwiMjAyMSJdLFsiTGFzdF9ZZWFyIiwiMjAyNCJdLFsiU2NhbGUiLCIwIl0sWyJTZXJpZXMiLCJBll1dfQ==* (Accessed August 18, 2025).

and other advantages; distributive impacts; and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. This interim final rule with comment period is significant as per section 3(f)(1) as we estimate that it will result in savings of $55,089,104,265 for long-term care facilities, patients and payors over 10 years, and costs of $3,255,827,043 for Medicare over 10 years (analogous effects for other payers were and are unquantified). As such, we have prepared a regulatory impact analysis that analyzes the costs and benefits of this interim final rule with comment period.

C. Impacts From Removing LTC Minimum Staffing Requirements

1. Costs Savings From Removing Staffing Requirements

We are removing two existing requirements for nursing services for LTC facilities at § 483.35. We are removing the requirement that facilities have RN coverage onsite 24 hours per day, 7 days a week (24/7 RN) and that they provide a minimum of 0.55 RN, 2.45 NA, and 3.48 total nurse staffing HPRD. Although Public Law 119–21 does not allow CMS to enforce the minimum staffing requirements until 2034, we follow guidance provided in OMB Circular A–4 *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf* that ''In some cases, substantial portions of a rule may simply restate statutory requirements that would be self-implementing, even in the absence of the regulatory action. In these cases, you should use a pre-statute baseline.'' As such, we continue to estimate the impact of removing these requirements even during the years when the Public Law 119–21 moratorium is in effect.

To estimate the impact from removing each of these requirements, we use the same methodology and data sources used to estimate the costs for these requirements in the 2024 Minimum Staffing final rule (89 FR 40948). We refer readers to that rule's regulatory impact analysis for a detailed discussion on the data sources and methodology for estimating the savings for removing each requirement as outlined in this section.[9] Since these requirements were phased in over a 5-year period starting in May 2024 and there were different timelines for rural and non-rural facilities to meet the requirements, there is yearly variation in the annual savings from removing each requirement. We note that the 10-year savings from removing these requirements are higher than the 10-year costs as outlined in the 2024 Minimum Staffing final rule (89 FR 40973) since more than a year has passed since the requirements were finalized and the phasing-in of the requirements led costs to be lower during the first 5 years after the effective date (than the eventual ongoing level). In addition, in line with the OMB guidance document M–25–20, we are adjusting all estimates to 2024 dollars using the Bureau of Economic Analysis' GDP deflator (National Income and Product Accounts Table 1.1.9).[10] [11]

a. RN Onsite 24 Hours a Day, 7 Days a Week (24/7 RN) Requirement Savings

To estimate the savings from removing the 24/7 RN requirement, we first calculated each facility's savings from not needing to have an RN onsite 24 hours a day, 7 days per week. We then aggregated the savings across all facilities for a total savings of $349 million annually for all facilities if these requirements had gone into effect in 2024.

The requirement that nursing homes provide 24/7 RN care included a phased-in implementation that requires non-rural facilities to meet the requirement by May 11, 2026, and rural facilities meeting the requirement by May 10, 2027. We also assumed that facilities would begin hiring RNs to meet this requirement in the year prior to the implementation deadline. As such, we calculated savings separately for rural and non-rural facilities. We estimate savings over 10 years starting in 2025 when this interim final rule with comment period removes the requirement. We include a 2.31 percent annual increase in real wage rates starting in 2025, which is the same wage increase used to estimate the requirement's cost in the 2024 Minimum Staffing final rule (89 FR 40975). As Table 2 shows, we estimate that removing this requirement results in average annual savings of approximately $431 million and $4,307,501,380 over 10 years.

TABLE 2—ANNUAL AND 10-YEAR SAVINGS FROM REMOVING THE 24/7 RN REQUIREMENT, BY RURAL/NON-RURAL LOCATION

Year	Calendar year	24/7 RN requirement		Total savings
		Rural	Urban	
Year 1	2025	$0	$242,980,786	$242,980,786
Year 2	2026	162,877,843	248,593,642	411,471,485
Year 3	2027	166,640,321	254,336,155	420,976,476

[9] Caveats about the earlier analysis continue to apply now. For instance, regulatory exemptions were and are generally not captured in the quantitative estimates. As an additional example, the quantitative approach continues to reflect an assumption that LTC facilities would reallocate their existing staffing resources to ensure compliance with the rule on a continual basis (for example, if a long-term care facility has a staffing level that is compliant with the 2024 rule over the course of a month or quarter, it may, in the absence of this interim final repeal and related statutory and judicial interventions, have needed to shift staff so that compliance would be achieved each day); data limitations were notable regarding the time LTC managers would spend on such reallocation in the presence of the 2024 rule.

[10] Office of Management and Budget. Guidance Implementing Section 3 of Executive Order 14192, Titled ''Unleashing Prosperity Through Deregulation''. *https://www.whitehouse.gov/wp-content/uploads/2025/02/M-25-20-Guidance-Implementing-Section-3-of-Executive-Order-14192-Titled-Unleashing-Prosperity-Through-Deregulation.pdf* (Accessed August 18, 2025).

[11] Bureau of Economic Analysis. ''National Income and Product Accounts.'' *https://apps.bea.gov/iTable/?reqid=19&step=3&isuri=1&1921=survey&1903=13#eyJhcHBpZCI6MTksInN0ZXBzIjpbMSwyLDMsM10sImRhdGEiOltbIk5JUEFfVGFibGVfTGlzdCIsIjEzIl0sWyJDYXRlZ29yaWVzIiwiU3VydmV5Il0sWyJGaXJzdF9ZZWFyIiwiMjAyMSJdLFsiTGFzdF9ZZWFyIiwiMjAyNCJdLFsiU2NhbGUiLCIwIl0sWyJTZXJpZXMiLCJBIl1dfQ==* (Accessed August 18, 2025).

TABLE 2—ANNUAL AND 10-YEAR SAVINGS FROM REMOVING THE 24/7 RN REQUIREMENT, BY RURAL/NON-RURAL LOCATION—Continued

Year	Calendar year	24/7 RN requirement		Total savings
		Rural	Urban	
Year 4	2028	170,489,712	260,211,321	430,701,033
Year 5	2029	174,428,024	266,222,202	440,650,227
Year 6	2030	178,457,312	272,371,935	450,829,247
Year 7	2031	182,579,676	278,663,727	461,243,402
Year 8	2032	186,797,266	285,100,859	471,898,125
Year 9	2033	191,112,283	291,686,689	482,798,972
Year 10	2034	195,526,977	298,424,651	493,951,628
10-Year Total Savings		1,608,909,413	2,698,591,967	4,307,501,380

b. Minimum Nurse Staffing Requirement of 3.48 Total Nurse Staffing HPRD, 0.55 RN HPRD, and 2.45 NA HPRD Savings

(1) 3.48 Total Nurse Staff HPRD Requirement Savings

To estimate the savings from removing the 3.48 total nurse staff HPRD requirement, we first calculated each facility's savings from not needing to hire nurse staff to meet the requirement. Then, we aggregated the savings across all facilities for a total savings of approximately $1.37 billion annually for all facilities if these requirements had gone into effect in 2024.

The requirement that nursing homes provide 3.48 total nurse staff HPRD included a phased-in implementation that requires non-rural facilities to meet the requirement by May 11, 2026, and rural facilities meeting the requirement by May 10, 2027. We also assumed that facilities would begin hiring staff to meet this requirement in the year prior to the implementation deadline. As such, we calculated savings separately for rural and non-rural facilities. We estimate savings over 10 years starting in 2025 when this interim final rule with comment period removes the requirement. We include a 2.31 percent annual increase in real wage rates starting in 2025, which is the same wage increase used to estimate the requirement's cost in the 2024 Minimum Staffing final rule (89 FR 40975). As Table 3 shows, we estimate that removing this requirement will result in average annual savings of approximately $1.75 billion and $17,460,934,208 over 10 years.

TABLE 3—ANNUAL AND 10-YEAR SAVINGS FROM REMOVING THE 3.48 TOTAL NURSE STAFF HPRD REQUIREMENT, BY RURAL/NON-RURAL LOCATION

Year	Calendar year	3.48 Total nurse staff		Total savings
		Rural	Urban	
Year 1	2025	$0	$1,315,408,430	$1,315,408,430
Year 2	2026	288,696,914	1,345,794,365	1,634,491,279
Year 3	2027	295,365,813	1,376,882,215	1,672,248,028
Year 4	2028	302,188,763	1,408,688,194	1,710,876,957
Year 5	2029	309,169,323	1,441,228,891	1,750,398,215
Year 6	2030	316,311,135	1,474,521,279	1,790,832,414
Year 7	2031	323,617,922	1,508,582,720	1,832,200,642
Year 8	2032	331,093,496	1,543,430,981	1,874,524,477
Year 9	2033	338,741,756	1,579,084,237	1,917,825,993
Year 10	2034	346,566,690	1,615,561,083	1,962,127,773
10-Year Total Savings		2,851,751,812	14,609,182,396	17,460,934,208

(2) 0.55 RN HPRD and 2.45 NA HPRD Requirements Savings

To estimate the savings from removing the 0.55 RN HPRD requirement and the 2.45 NA HPRD requirement, we first calculated each facility's savings from not needing to hire RNs to meet the RN HPRD requirement and NAs to meet the 2.45 NA HPRD requirement. We then aggregated the savings across all facilities for a total savings of approximately $2.91 billion annually for all facilities if these requirements had gone into effect in 2024.

The requirement that nursing homes provide 0.55 RN HPRD and 2.45 NA HPRD included a phased-in implementation that requires non-rural facilities to meet the requirement by May 10, 2027, and rural facilities meeting the requirement by May 10, 2029. We also assumed that facilities would begin hiring staff to meet this requirement in the year prior to the implementation deadline. As such, we calculated savings separately for rural and non-rural facilities. We estimate savings over 10 years starting in 2025 when this interim final rule with comment period removes the requirement. We include a 2.31 percent annual increase in real wage rates starting in 2025, which is the same wage increase used to estimate the requirement's cost in the 2024 Minimum Staffing final rule (89 FR 40975). As Table 4 shows, we estimate that removing these requirements will result in average annual savings of approximately $3.3 billion and $33,004,996,355 over 10 years.

TABLE 4—ANNUAL AND 10-YEAR SAVINGS FROM REMOVING THE 0.55 RN AND 2.45 NA HPRD REQUIREMENTS, BY RURAL/NON-RURAL LOCATION

Year	Calendar year	0.55 RN HPRD		2.45 NA HPRD requirement		Total savings
		Rural	Urban	Rural	Urban	
Year 1	2025	$0	$0	$0	$0	$0
Year 2	2026	0	1,096,966,133	0	1,772,028,616	2,868,994,750
Year 3	2027	0	1,122,306,051	0	1,812,962,477	2,935,268,528
Year 4	2028	210,818,944	1,148,231,321	410,835,718	1,854,841,911	3,624,727,894
Year 5	2029	215,688,862	1,174,755,464	420,326,023	1,897,688,759	3,708,459,108
Year 6	2030	220,671,275	1,201,892,315	430,035,554	1,941,525,369	3,794,124,513
Year 7	2031	225,768,781	1,229,656,028	439,969,375	1,986,374,605	3,881,768,790
Year 8	2032	230,984,040	1,258,061,082	450,132,668	2,032,259,859	3,971,437,649
Year 9	2033	236,319,771	1,287,122,293	460,530,733	2,079,205,061	4,063,177,858
Year 10	2034	241,778,758	1,316,854,818	471,168,993	2,127,234,698	4,157,037,267
10-Year Total Savings		1,582,030,432	10,835,845,505	3,082,999,063	17,504,121,355	33,004,996,355

Table 5 summarizes the total savings from removing the 24/7 RN requirement, as well as the 0.55 RN, 2.45 NA, 3.48 total nurse staffing HPRD requirements, and the information collection costs as outlined in Table 1, but not the regulatory review costs which we discuss in more detail later in this section. Overall, we estimate that rescinding these requirements will result in approximately $5.51 billion in annual savings for nursing home providers with total savings over 10 years estimated at $55,089,104,265.

TABLE 5—ANNUAL AND 10-YEAR SAVINGS FROM REMOVING THE 24/7 RN, 3.48 TOTAL NURSE STAFF, 0.55 RN AND 2.45 NA HPRD REQUIREMENTS, BY RURAL/NON-RURAL LOCATION

Year	Calendar year	0.55 RN and 2.45 NA HPRD collection of information	24/7 RN requirement		3.48 Total nurse staff		0.55 RN HPRD		2.45 NA requirement		Total savings
			Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	
Year 1	2025	$28,423,085	$0	$242,980,786	$0	$1,315,408,430	$0	$0	$0	$0	$1,586,812,302
Year 2	2026	29,079,658	162,877,843	248,593,642	288,696,914	1,345,794,365	0	1,096,966,133	0	1,772,028,616	4,944,037,172
Year 3	2027	29,751,398	166,640,321	254,336,155	295,365,813	1,376,882,215	0	1,122,306,051	0	1,812,962,477	5,058,244,430
Year 4	2028	30,438,656	170,489,712	260,211,321	302,188,763	1,408,688,194	210,818,944	1,148,231,321	410,835,718	1,854,841,911	5,796,744,539
Year 5	2029	31,141,789	174,428,024	266,222,202	309,169,323	1,441,228,891	215,688,862	1,174,755,464	420,326,023	1,897,688,759	5,930,649,338
Year 6	2030	31,861,164	178,457,312	272,371,935	316,311,135	1,474,521,279	220,671,275	1,201,892,315	430,035,554	1,941,525,369	6,067,647,338
Year 7	2031	32,597,157	182,579,676	278,663,727	323,617,922	1,508,582,720	225,768,781	1,229,656,028	439,969,375	1,986,374,605	6,207,809,991
Year 8	2032	33,350,151	186,797,266	285,100,859	331,093,496	1,543,430,981	230,984,040	1,258,061,082	450,132,668	2,032,259,859	6,351,210,402
Year 9	2033	34,120,540	191,112,283	291,686,689	338,741,756	1,579,084,237	236,319,771	1,287,122,293	460,530,733	2,079,205,061	6,497,923,362
Year 10	2034	34,908,724	195,526,977	298,424,651	346,566,690	1,615,561,083	241,778,758	1,316,854,818	471,168,993	2,127,234,698	6,648,025,392
10-Year Total Savings		315,672,322	1,608,909,413	2,698,591,967	2,851,751,812	14,609,182,396	1,582,030,432	10,835,845,505	3,082,999,063	17,504,121,355	55,089,104,265

2. Costs From Removing LTC Staff Requirements

To estimate the cost for removing the comprehensive minimum staffing standard requirements, we use the same methodology and data sources used to estimate the savings for these requirements in 2024 Minimum Staffing final rule (89 FR 40955). We refer readers to that rule's regulatory impact analysis for a detailed discussion on the data sources and methodology. As we detailed in that final rule, the financial savings for Medicare that we estimated from these requirements are related to the 0.55 RN HPRD requirement that is phased in over a 5-year period starting in May 2024. Since more than a year has passed since the requirements were finalized and we estimated no savings during the first 2 years after finalization, the cost for removing this requirement will be higher than its estimated savings in the 2024 Minimum Staffing final rule (89 FR 40878). Overall, we estimate that removing this requirement will cost Medicare $326 million annually and $3,255,827,043 over 10 years.

TABLE 6—COSTS FOR REMOVING 0.55 RN HPRD REQUIREMENT

Year	Calendar year	Medicare costs
Year 1	2025	$0
Year 2	2026	361,758,560
Year 3	2027	361,758,560
Year 4	2028	361,758,560
Year 5	2029	361,758,560
Year 6	2030	361,758,560
Year 7	2031	361,758,560
Year 8	2032	361,758,560
Year 9	2033	361,758,560
Year 10	2034	361,758,560
10-Year Total Savings	.....	3,255,827,043

3. Transfers Associated With Rescinding the LTC Minimum Staffing Requirements

In the regulatory impact analysis for the 2024 final rule (see 89 FR 40909), we explained that there is uncertainty about the degree to which LTC facilities would bear the cost of meeting the minimum staffing and 24/7 RN requirements and how much of the costs would be passed onto payors (including Medicaid, Medicare, private insurers, and nursing facility residents). We assumed that LTC facilities would generally have 3 possible approaches to addressing the increased costs associated with the higher staffing levels: (1) reduce their margin or profit; (2) reduce other operational costs; and (3) increase prices charged to payors. LTC facilities may use some combination of these approaches, and those approaches could vary by facility and over time. These decisions could depend on a number of factors, including: the current margin levels of a facility; the cost increase due to the staffing requirements relative to current costs and revenues; the current level of operational costs; and the ability to negotiate prices with payors.

Furthermore, we noted in the 2024 final rule that if costs were to be passed through to payors then we could estimate those costs would be passed to payors at a distribution rate of—Medicaid 67 percent; Medicare 11 percent; and Other Payors/Residents 22 percent.[12] Given the variety and uncertainty regarding transfers to payors and to preserve continuity between the estimates discussed in the 2024 final rule and the savings estimated in this IFC, we have not estimated transfers associated with the 24/7 RN, 3.48 total nurse staff HPRD, 0.55 RN HPRD, and the 2.45 NA HPRD requirements, including potential transfers associated with Medicare, Medicaid, and other non-Medicare/Medicaid payors avoiding increases in payment rates in response to the repeal of the 2024 requirements.

D. Alternatives Considered

In developing this interim final rule with comment period, we considered feedback from interested parties following the publication of the final rule that established the staffing standards we are now removing. Specifically, long-term care facilities, especially those within rural and tribal communities, raised significant concern that these standards could increase the risk of facility closure. In addition, a legislative moratorium precludes the agency from enforcing these standards until 2034. While we considered retaining the rules without enforcement until the end of the moratorium in 2034, ultimately, we decided to remove these requirements to avoid unintended implementation challenges and confusion for LTC facilities.

E. Regulatory Review Cost Estimation

Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that 75 percent of all long-term care facilities will review this interim final rule with comment period. We acknowledge that this assumption may understate or overstate the costs of reviewing this interim final rule with comment period. It is also possible that other individuals and providers will review this interim final rule with comment period. For these reasons we believe that the number of Medicare and Medicaid-certified long-term care facilities (n = 14,752) would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this interim final rule with comment period, and therefore, for the purposes of our estimate, we assume that each reviewer reads approximately 75 percent of the interim final rule with comment period. We seek comments on this assumption.

Using the wage information from the Bureau of Labor Statistics (BLS) May 2024 Occupational Employment and Wage Statistics for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this interim final rule with comment period

[12] Based on facility level data on the percentage of resident days paid for by Medicaid, Medicare, and other payors, we estimated the potential share of costs for each payor by weighting each facility's increased costs by the percentage of resident days paid for by each payor type.

is $132.44 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately ([7,000 words/250 words per minute] × 75 percent) 22 minutes for the staff to review 75 percent of this interim final rule with comment period. For each entity that reviews the interim final rule with comment period, the estimated cost is $48.56 (0.37 hours × $132.44). Therefore, we estimate that the total cost of reviewing this regulation is $716,357 ($[48.56] × [14,752]).

F. Accounting Statement

As required by OMB Circular A–4 (available online at *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf*), we have prepared an accounting statement in Table 6 showing classification of the costs and benefits associated with the provisions of this interim final rule with comment period. This includes the total savings from removing the 24/7 RN and the 3.48 total nurse staff HPRD, 0.55 RN HPRD, and 2.45 NA HPRD requirements as provided in Table 5, as well as the increased in Medicare spending as provided in Table 6, and the total cost for the regulatory review that we estimated at $716,357. There are zero dollars in transfer estimates in the statement. This statement provides our best estimate for the Medicare and Medicaid provisions of this rule.

TABLE 7—ACCOUNTING STATEMENT

Category	Estimates	Units		
		Year dollar	Discount rate (%)	Period covered
Benefits:				
Annualized Monetized ($million/year)	5,412	2024	3	2025–2034
Annualized Monetized ($million/year)	5,282	2024	7	2025–2034
Costs:				
Annualized Monetized ($million/year)	321	2024	3	2025–2034
Annualized Monetized ($million/year)	314	2024	7	2025–2034

G. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that almost all Skilled Nursing Facilities (NAICS 623110) are considered small businesses either by the Small Business Administration's size standards with total revenues of $34 million or less in any single year or by their non-profit status. Individuals and states are not included in the definition of a small entity. According to the 2022U.S. Census Bureau,[13] in 2022 Skilled Nursing Facilities (NAICS 623110) had revenues of approximately $137.05 billion. Updated for inflation, this is approximately $155.01 billion in 2024 dollars.[14] As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent with an emphasis in the guidance on increased costs due to regulation. Since this interim final rule with comment period does not impose any new costs on nursing homes and is estimated to save them an average of $5.5 billion annually during the first 10 years due to the removal of the 24/7 RN requirement as well as the 0.55 RN, 2.45 NA, and 3.48 total nurse staff HPRD staffing requirements and associated collection of information costs as indicated in Table 5, it will not have a significant economic impact on a substantial number of small businesses or other small entities as measured by a change in revenue of 3 to 5 percent. Therefore, the Secretary has certified that this interim final rule with comment period will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For the purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This interim final rule with comment period does not impose any costs on small rural hospitals. These proposals pertain solely to SNFs and NFs. Therefore, the Secretary has certified that this interim final rule with comment period will not have a significant impact on the operations of a substantial number of small rural hospitals.

H. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. This interim final rule with comment period does not mandate any requirements for State, local, or tribal governments, or for the private sector.

Therefore, no analysis is required under the UMRA.

I. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates an interim final rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This interim final rule with comment period will not have a substantial direct effect on state or local governments, preempt states, or otherwise have a Federalism implication.

J. E.O. 14192, ''Unleashing Prosperity Through Deregulation''

Executive Order 14192, titled ''Unleashing Prosperity Through

[13] U.S. Census Bureau. ''2022 SUSB Annual Data Tables by Establishment Industry.'' *https://www.census.gov/data/tables/2022/econ/susb/2022-susb-annual.html.* Accessed on August 20, 2025

[14] Bureau of Economic Analysis. ''National Income and Product Accounts.'' *https://apps.bea.gov/iTable/?reqid=19&step=3&isuri=1&1921=survey&1903=13#eyJhcHBpZCI6MTksInN0ZXBzIjpbMSwyLDMsM10sImRhdGEiOltbIk5JUEFfVGFibGVfTGlzdCIsIjEzIl0sWyJDYXRlZ29yaWVzIiwiU3VydmV5Il0sWyJGaXJzdF9ZZWFyIiwiMjAyMSJdLFsiTGFzdF9ZZWFyIiwiMjAyNCJdLFsiU2NhbGUiLCIwIl0sWyJTZXJpZXMiLCJBIl1dfQ==* (Accessed August 18, 2025).

Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.'' We followed the implementation guidance from OMB–M–25–20 (*https://www.whitehouse.gov/wp-content/uploads/2025/02/M-25-20-Guidance-Implementing-Section-3-of-Executive-Order-14192-Titled-Unleashing-Prosperity-Through-Deregulation.pdf*) when estimating the interim final rule's impact related to the executive order. Specifically, we used a 7 percent discount rate when estimating the cost savings and counted savings only from removing the minimum staffing requirements. We did not include increased costs to Medicare since the OMB guidance indicates that benefits from regulation should not be counted as '''negative cost savings' when deregulating.''

Using the totals in Table 5, we estimate that for the purposes of E.O. 14192, the deregulatory efforts in this interim final rule with comment period will result in annual cost savings of $5.28 billion (calculated with a 7-percent discount rate) over a perpetual time horizon.

In accordance with the provisions of E.O. 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

VII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on November 26, 2025.

List of Subjects in 42 CFR Part 483

Grant programs—health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR part 483 as follows:

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

■ 1. The authority citation for part 483 continues to read as follows:

Authority: 42 U.S.C. 1302, 1320a-7, 1395i, 1395hh, and 1396r.

§ 483.5 [Amended]

■ 2. Section 483.5 is amended by removing the definition of ''Hours per resident day''.

■ 3. Section 483.35 is revised to read as follows:

§ 483.35 Nursing services.

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.71.

(a) *Sufficient staff.* (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans—

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans, and responding to resident's needs.

(b) *Registered nurse.* (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full-time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(c) *Proficiency of nurse aides.* The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(d) *Requirements for facility hiring and use of nursing aides*—(1) *General rule.* A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual—

(i) Is competent to provide nursing and nursing related services; and

(ii)(A) Has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§ 483.151 through 483.154; or

(B) Has been deemed or determined competent as provided in § 483.150(a) and (b).

(2) *Non-permanent employees.* A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.

(3) *Minimum competency.* A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—

(i) Is a full-time employee in a State-approved training and competency evaluation program;

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or

(iii) Has been deemed or determined competent as provided in § 483.150(a) and (b).

(4) *Registry verification.* Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual—

(i) Is a full-time employee in a training and competency evaluation program approved by the State; or

(ii) Can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that the individual actually becomes registered.

(5) *Multi-State registry verification.* Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.

(6) *Required retraining.* If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

(7) *Regular in-service education.* The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of § 483.95(g).

(e) *Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis.* To the extent that a facility is unable to meet the requirements of paragraphs (a)(1) and (b)(1) of this section, a State may waive the requirements with respect to the facility if—

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in paragraph (e) of this section is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their resident representatives of the waiver.

(f) *SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.* (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) The facility either—

(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period; or

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders; and

(v) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (f)(1) of this section is subject to annual renewal by the Secretary.

(g) *Nurse staffing information*—(1) *Data requirements.* The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

(iv) Resident census.

(2) *Posting requirements.* (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) *Public access to posted nurse staffing data.* The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) *Facility data retention requirements.* The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2025–21792 Filed 12–2–25; 8:45 am]

BILLING CODE 4120–01–P