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Senate of Pennsylvania

August 27, 2021

Alison Beam, Acting Secretary
Pennsylvania Department of Health
Health and Welfare Building
8th Floor West; 625 Forster Street
Harrisburg, PA 17120

Dear Acting Secretary Beam,

We are writing today regarding Proposed Regulation #10-221 (Long-Term Care Nursing Facility Regulations, part 1) and their unintended consequences on some of our most vulnerable residents issued by the Department of Health (DOH).

While we appreciate the fact that the DOH is finally attempting to update regulations for long-term care nursing facilities since 1999, we wish to communicate our opposition to the proposed rulemaking which increases the minimum number of direct resident care hours from 2.7 to 4.1.

As a nurse, Senator Ward fully understands the challenges of providing direct care to patients and we both understand the need to provide both quality care and a quality of life for residents. That said, we have serious concerns with mandating a higher minimum number of direct resident care hours per day in Skilled Nursing Facilities (SNF) as proposed in this rule, which could further limit access to 24-7 care to consumers.

As you are aware, 4.1 hours is only a suggestion, not a requirement from the federal Centers for Medicare & Medicaid Services (CMS). As a matter of fact, on page 15 of the narrative in your proposed rulemaking, the following comments make the case against raising the minimum number of care hours:

> *CMS declined to include a minimum number of direct care hours when it proposed to update the Federal requirements in 2015. CMS agreed that the existing staffing requirements needed to be clarified but believed that it did not have sufficient information at the time to require a specific number of staffing hours. CMS was also concerned that requiring specific numbers would conflict with requirements already established by states and "would limit flexibility and innovation in designing new models of person-centered care delivery to residents.*

The narrative further states what CMS proposed and their response to why they did not mandate minimum staffing hours:

> *Instead, CMS proposed language that would require nursing staff to possess the appropriate competencies and skills to provide health care and services to residents in long-term care facilities. CMS also proposed that long-term care facilities use a facility assessment to determine direct care staff needs. In the final rulemaking, CMS responded to concerns about its failure to implement required minimum staffing hours, by reiterating that it was concerned that a mandated ratio could have unintended consequences such as staffing to a minimum, input substitutions (hiring for one position by eliminating another), task diversion (assigning non-standard tasks to a position) and the stifling of innovation.*

DOH's review of surrounding states in terms of minimum direct care nursing hours revealed that most of them have a lower minimum requirement (New York – no minimum, sufficient staffing; West Virginia – 2.25 hours; Ohio and New Jersey – 2.5 hours) than Pennsylvania's 2.7 hours. As such, we are not convinced that Pennsylvania needs yet another mandate, because in reality, numerous facilities in Pennsylvania have decided to provide a higher number of resident care hours than the minimum level without being mandated to do so when feasible.

We are also concerned that mandating additional hours could result in numerous SNF's closing their doors, which would be detrimental to the health and well-being of thousands of seniors. As you know, workforce has been a major struggle for the long-term care industry and this problem has only been exacerbated due to COVID-19. As such, now is not the time to force nursing homes to implement higher minimum staffing hours. Unfortunately, the department's recommendation is tone deaf, in that it would require nearly 7,000 more direct care workers according to the Pennsylvania Health Care Association. Instead of raising the minimum number of care hours, DOH needs to focus on workforce development strategies so that the industry can have the workers needed to deliver high quality care.

Further, the cost to increase the minimum care hours will be significant to SNFs and directly to consumers. Is the department going to guarantee that they are going to lighten the load of costs elsewhere? Most of us in the General Assembly have had a loved one in a nursing facility and want the best quality of care possible for them. It is unfortunate that the department is not focusing on burdensome red tape bureaucracy that has nothing to do with patient safety or care. If the department would focus on streamlining processes for reporting and removing duplicative requirements to decrease the time spent on paperwork, then nurses and staff would have more time to focus on providing patient care. For example, streamline requirements that staff report to one system or process for both their state and federal licenses; and create an integrated system for reporting allegations of harm or abuse that would require the state agencies to coordinate, rather than duplicating provider efforts and doubling the amount of time it takes to do so.

It is estimated that the cost could be roughly $366 million annually. While the department indicates that a portion of the costs may be covered by federal Medicaid reimbursement, the state would still need to commit over $173 million. How does the department propose to subsidize the increase of these costs that will directly impact consumer access to this level of care? Currently about 2 in 3 nursing facility residents are enrolled in Medicaid, and the other third primarily rely on their ability to pay privately. We have already priced consumers out of these facilities or worse, required them to spend down all of their assets to become Medicaid eligible and thus reliant on public funds to maintain their nursing facility care. It is no secret that Medicaid is a poor payor and only covers a fraction of the costs it takes to provide quality care. Are we to expect a nursing facility bed shortage next?

The cost, coupled with the workforce shortage, makes this change nearly impossible for facilities to implement, thus crippling the industry and potentially putting at risk the health and safety of our most vulnerable population. In fact, we are already aware of facilities putting holds on new admissions and closing entire wings of their facilities due to workforce shortages.

In addition to the current minimum threshold of 2.7 hours, it is our understanding that the department already has authority to require additional staff it perceives necessary. These state-specific powers, combined with several CMS tools like Payroll Based Journal staffing data and Facility Assessments, provide surveyors with substantial authority and insight to oversee staffing in nursing facilities.

Given that the proposed rule incorporates and references the federal rules, we recommend that any minimum direct care hour requirement imposed on nursing facilities recognize the direct care services provided by all staff, including but not limited to staff providing therapy, dietary, activities, and social services, etc., not only the care provided by RNs, LPNs and CNAs. It is our understanding that CMS defines "direct care staff" to include any staff person who provides care and services to allow residents to attain or maintain the highest practicable physical, mental and psychosocial well-being.

DOH needs to partner with the long-term care industry in addressing issues like this rather than developing a regulation without input from those on the frontline. We were dismayed to learn that your department disbanded the working group after initial feedback from the industry in 2017 and 2018. Unfortunately, the department has not learned its lesson from the COVID-19 pandemic in failing to collaborate with the industry in combatting the virus and administering vaccines. This is just another example of the department's unwillingness to work with the industry.

In conclusion, we respectfully request that the department forgo any change in the minimum number of direct resident care hours and ask instead that you collaborate with those on the frontline when developing the final regulation. In addition, we urge the department to consider innovative staffing and recruitment strategies to improve the supply of workers while continuing to use the 2.7 minimum staffing standard and its current authority to require increased staffing when necessary.

Thank you for your consideration as DOH reviews and develops a final-form regulation that is responsible and reasonable. We look forward to reviewing the subsequent sections of this proposed rulemaking once available for public comment.

Sincerely,

Senator Judy Ward
30th Senate District

Senator Michele Brooks
50th Senate District

cc: George Bedwick, Chair of Independent Regulatory Review Commission