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Independent Regulatory Review Commission

UPMC | SENIOR COMMUNITIES

Lori Gutierrez
Deputy Director, Office of Policy
PA Department of Health
625 Forster Street, Room 814
Health and Welfare Building
Harrisburg, PA 17120

August 25, 2021

Dear Ms. Gutierrez:

UPMC Senior Communities appreciates the opportunity to submit comments on the Department of Health's proposed Rulemaking 10-221 that was published in the *Pennsylvania Bulletin* on July 31. UPMC Senior Communities serves over 3,000 residents daily in skilled nursing, memory care, assisted living, personal care, and independent living in both Continuing Care Retirement Center (CCRC) and stand-alone communities in 28 facilities in 11 counties, including Venango, Mercer, Lawrence, Butler, Allegheny, Washington, Westmoreland, Clinton, Potter, Tioga, and Lycoming.

While the proposed regulations seek to require nursing homes to increase the requirements for staff from 2.7 Nursing Hours Per Patient Day (NHPPD) to 4.1 NHPPD on each shift, we have validated concerns in the following areas:

- Staffing crisis
- Chronic underfunding
- Impact on quality – NHPPD does not equal quality

Staffing Crisis

Staffing shortages only increased as COVID-19 surged in nursing homes across the Commonwealth, and the shortages seemed to have taken a toll on nursing homes, including UPMC Senior Communities as illustrated in Exhibit 1 in vacancy rates.

UPMC Senior Communities has **567 current positions in recruitment** and vacancy rates in the following disciplines are noted below. We are currently using third-party agency staffing for 145 positions.
At multiple times over the past year, we have needed to refuse to accept new admissions of resident needing care due to staffing limitations.

RN/LPN → 40.55 % vacancy rate
CNA/NA → 30.01 % vacancy rate

*PP=Percentage Points

Exhibit 1

				2021 vs 2020		2021 vs 2019	
Employee Groups	**2019**	**2020**	**2021**	**PP**	**%**	**PP**	**%**
Overall	10.16	15.06	22.25	7.19	47.7%	12.09	119.0%
RN/LPN	15.8	27.56	40.55	12.99	47.1%	24.75	156.6%
CNA/NA	13.48	18.48	30.01	11.53	62.4%	16.53	122.6%

Observations:

Overall Vacancies have increased by 7.19 percentage points or 47.7% during pandemic, and by 12.09 percentage points or 119% prior to onset of pandemic
RN/LPN Vacancies have increased by 12.99 percentage points or 47.1% during pandemic, and by 24.75 percentage points or 156.6% prior to onset of pandemic
CNA/NA Vacancies have increased by 11.53 percentage points or 62.4% during pandemic, and by 16.53 percentage points or 122.6% prior to onset of pandemic

COVID-19 exposed existing nursing home staffing shortages and turned these challenges into a full-blown crisis with enhanced unemployment benefits and competing job opportunities also playing a role. While COVID-19 vaccines have brought relief inside nursing homes as resident and staff infections have declined,[1] they have also created another staffing challenge for administrators concerned that workers will walk away if they are required to get the vaccine, further exacerbating the shortfall.[2] Not requiring similar mandates for other levels of health care providers, such as hospitals or physician offices, will worsen the "flight" from nursing facilities because there are other places also suffering from the staffing shortages and no shortage of other opportunities elsewhere for these same pool of workers. We acknowledge providers of health care and nursing services are in constant and ever-more expensive competition for the same small cohort of eligible and interested workers. **Mandating a 50 percent increase in nursing home staffing will have broad and detrimental effects across all health care sectors.**

DOH proposes the implementation timeline for this package to be effective immediately upon publication as final; however, the shortage of available workers to achieve compliance with a mandate could lead to challenges with access to nursing home care, particularly in rural areas.

Therefore, we recommend DOH allow nursing facilities **at least one year** from publication of the final regulations to comply with any increase in staffing minimums before citations for non-compliance can be issued. DOH should clarify: 1) situations in which exceptions are necessary; 2) what happens when a facility is not able to comply.

We also recommend the Commonwealth take substantive and meaningful action on addressing the workforce shortage consistent with PA Department of Aging's Blueprint for Strengthening Pennsylvania's Direct Care Workforce.[3]

Furthermore, the first part of the DOH regulation package only addresses definitions and staffing minimums. Subsequent packages, including new minimum staffing ratios, are forthcoming. As a result, we are concerned that releasing these packages in a piecemeal fashion may lead to confusion by providers, regulators, and the public. There could also be significant discrepancies and lack of clarity utilizing this strategy.

Additionally, we request that DOH not implement any parts of the regulatory package until all parts are issued and there is a minimum of a 30-day public comment period on the entire regulatory package followed by a full regulatory review process.

Chronic underfunding

As the primary financiers for short-and long-term nursing home stays respectively, the payment rules of Medicare and Medicaid will play crucial roles in realizing a new vision – post COVID – for the appropriate services and settings for the care nursing homes currently provide.

Nursing homes in one of the nation's oldest states have not received any increase in state Medicaid program funding – the largest payer of nursing home care – for the past seven years even though inflation for health care has increased dramatically.

Even the best nursing home providers cannot provide the highest quality care with diminishing funds. As evidenced by a LeadingAge Pennsylvania statistical analysis of the industry, the cost of care has risen by 33 percent while Medicaid rates have only increased by 1percent, resulting in an average annual loss to nursing facilities of $17,000 per resident.

[1] Sustained Drop in Covid-19 Nursing-Home Deaths Points to Vaccinations - WSJ
[2] Biden Nursing Home Vaccine Mandate Expected to Devastate CNA Recruitment, Retainment - Skilled Nursing News
[3] LTCC Blueprint for Strengthening Pennsylvania's Direct Care Workforce_APR19 (pa.gov)

The status quo financing of nursing homes in Pennsylvania is not sustainable. Unless the reimbursement rates paid by the Medicaid program are brought more in alignment with the costs of providing high quality care in a safe manner, providers will be unable to care for the Commonwealth's most vulnerable residents and already strained family caregivers will be that much more burdened.

While DHS has made some projections of costs, there is no guarantee that these funds will be included in the budget, or that increased payments will be made to nursing facilities by the Community HealthChoices Managed Care Organizations. Additionally, there is no recognition by DOH that providers may need to raise private-pay rates, thereby increasing the numbers of individuals that spend down assets and add to the Medical Assistance spending.

We fervently believe that the reimbursement methodologies and operating parameters of states cited by the DOH, including Florida, Alaska, Idaho, Oregon, and Utah, must be compared in addition to their staffing requirements. Comparing staffing requirements without also comparing both operational and reimbursement structures is disingenuous and myopic.

For example, in its proposal, DOH cites legislation in Connecticut that, if passed and enacted, will establish a minimum requirement of 4.1 direct care nursing hours for 209 nursing homes.[4] The Rhode Island Senate also recently passed a bill, which, if enacted, will require its 78 nursing facilities to provide a minimum daily average of 4.1 hours of direct nursing care per resident, per day.[5]

It is important to underscore that both Connecticut and Rhode Island joined North Carolina and Oregon to boost Medicaid nursing home rates last year. For example, Connecticut received 15 percent Medicaid boost. Initially, state officials announced a 10 percent rate increase for providers. It later added another five percent boost after calling on the state to do more to prevent a financial collapse of the sector.[6] [7]

Moreover, Pennsylvania is one of only a handful of states whose Medicaid program does not provide reimbursement for personal care and assisted living facilities. Much analysis has been done on the impact of funding assisted living in Pennsylvania.[8] By reexamining this issue, the Commonwealth should be able to both decrease its overall funding for seniors and allocate dollars and staffing where it is needed – *caring for the disproportionate share of residents above the age of 80, who are frail and have chronic, preexisting conditions in skilled nursing facilities.*

Managed care organizations now handle most of the Commonwealth's Medicaid population, and allowing these organizations the flexibility to provide funding for care in the best available setting is actuarily sound policy. Additionally, caring for residents in primary private assisted living accommodations will result in:

- decreased infection transmission
- decreased agitation
- decreased the need for medication
- increased in satisfaction among resident and family

NHPPD does not equal quality

At UPMC Senior Communities, our care is team-based and a lack of flexibility to provide staffing based on the acuity of individual patient needs would jeopardize safe patient care. To truly commit to patient safety – always the number one priority – our care team needs to be empowered with flexibility to determine appropriate staffing for the needs of their patients. **The quality of a resident's life is significantly affected by care that is competent, compassionate, and responsible.**

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[4] Raised S.B. 1030, General Assembly Reg. Session (Conn. 2021).
[5] Nursing Home Staffing and Quality Care Act, S.B. 0002, General Assembly Reg. Session (R.I. 2021).
[6] CT hospitalizations continue to fall, Lamont pledges more money for nursing homes (ctpost.com)
[7] Opinion/Gifford: Bill poses burdens to RI's nursing homes (msn.com)
[8] https://www.phca.org/for-consumers/research-data/alpc

UPMC Senior Communities encourages the Department of Health to promote the active engagement with both medical directors and adjunct provider teams in establishing appropriate staffing recommendations.

Moreover, Pennsylvania's approach to funding various levels of care and the acuity of skilled nursing residents must be considered when analyzing staffing requirements and reimbursement. Many skilled nursing residents are only in skilled facilities because of the limitations of the Medicaid program and the limited financial means therein. The care hours required by residents' needs and resident census change daily and even hour by hour. As more residents are diagnosed with dementia or other cognitively impaired related diagnosis – 14 percent by 2025 – facilities should have the flexibility and resources to staff adequately based on needs specific to this population.[9]

Placing all residents into a single staffing requirement, no matter the number, is a failure to recognize this fact for the purpose of simplicity.[10] The PA Bulletin cites an integrated literature review of the relationship between staffing and quality outcomes in nursing homes. The study pronounces the importance of considering staffing composition and the clear need to further evaluate the issue since the reviewed studies have not clearly defined the relationship between differing levels of nurse-staffing skill mix and specific structural, process, outcome, and composite indicators of quality. Moreover, it states there is not enough information to determine a specific staffing ratio.

As a matter of fact, the conclusion[11] states: *Nurse staffing is a key factor to improve QOC and QOL for NH residents. Original studies of 28 articles during the past 10 years were reviewed. The findings reported inconsistent findings of the relationship between nurse staffing and resident outcomes. Further research is needed, including investigating the relationship between nurse staffing and QOC or QOL and developing integrative review papers to have a higher level of evidence that can be used for determining optimized nurse staffing levels.*

We recommend that any decisions about staffing consider the broader issues[12], including:

- the complexity and acuity of a facility's population;
- the functional level of residents and services required;
- creating consistent work schedules that are flexible to accommodate the changing needs of the residents along with improving consistent communication and documentation regarding the care needs of residents;
- the existence of staffing shortages for some types of staff in some geographic locations, and temporary staffing shortages due to such events as employee illness or termination;
- defining and including other categories of caregivers, such as medication aides, feeding assistants, restorative aides, family members, and activities professionals; being more flexible and to allow nimble response to the market dynamics;
- the quality, competence, and engagement of staff leadership and supervision;
- addressing adequacy of training and skills development, and
- the career and educational development of staff (especially among newly licensed nurses).

Moreover, we endorse building on existing relevant regulations, such as the F838 Facility Assessment that was included in the 2016-2019 updated OBRA regulations, instead of creating new state mandates.[13] Given DOH nursing facility regulations and several new tools from Centers of Medicare and Medicaid Services (CMS) that include Payroll Based Journal (PBJ), which is a verifiable set of staffing data, DOH surveyors already have substantial authority and insight to oversee staffing in nursing facilities.

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[9] https://www.alz.org/media/documents/alzheimers-facts-and-figures-2019-r.pdf
[10] Shin JH, Bae SH. Nurse staffing, quality of care, and quality of life in US nursing homes, 1996–2011: an integrative review. J Gerontol Nurs. 2012 Dec;38(12):46-53. doi: 10.3928/00989134-20121106-04. PMID: 23362520.
[11] Ibid.
[12] https://paltc.org/sites/default/files/AMDA%20Staffing%20Standards.pdf
[13] https://www.licamedman.com/ftag/872/f838-facility-assessment

UPMC Senior Communities welcomes the opportunity to further collaborate with DOH and industry stakeholders to develop new strategies to better match the care provided with the needs of the varied subsets of the institutional long-term care population using verifiable PBJ data.

Specifically, we recommend the Commonwealth fund a study through several academic medical centers in the state to reconfirm how best to : 1) match patients with specific needs with appropriate care models; 2) increase training and payment for the skilled nursing staff in these facilities; and 3) examine the financing and payment structures that support these facilities.

We stand ready to assist in what would be an obvious first step to ensuring that nursing home residents receive effective and efficient care.

Sincerely,

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