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Independent Regulatory Review Commission

PHCA
PENNSYLVANIA HEALTH CARE ASSOCIATION

August 30, 2021

Department of Health
625 Forster Street
Harrisburg, PA 17120
Attn: Lori Gutierrez, Deputy Secretary
Office of Policy

Re: Rulemaking 10-221 (Long-Term Care Facilities, Proposed Rulemaking 1)

To Whom It May Concern,

We are writing today regarding the Department of Health, Long-Term Care Facilities, Proposed Rulemaking 1, Rulemaking 10-221.

Please accept these comments on behalf of the Pennsylvania Health Care Association (PHCA), and the four-hundred long-term care facilities we represent throughout the commonwealth, including nursing homes, personal care homes and assisted living communities.

During the past eighteen months, PHCA has been proud to advocate on behalf of those four-hundred facilities, as well as their providers, frontline caregivers, and residents – all of whom have remained at the epicenter of the COVID-19 pandemic.

Throughout the pandemic, during legislative hearings and in public forums, we've called for critical resources for our workers, such as PPE, testing, and staffing; we've fought for funding, so that providers could sustain their operations; and we've asked, time and time again, for collaboration and support from state leaders, because our providers need strong partners in government to be successful.

Today is no different.

In mid-July, our membership watched, in disbelief, as the Departments of Health and Human Services announced the first phase of new nursing home regulations, which included a minimum staffing ratio of 4.1 PPD.

At the height of a global pandemic and workforce shortage, how could the regulatory agencies tasked with overseeing our industry introduce an initiative so disconnected with the reality facing hundreds of nursing homes throughout the state?

PHCA has, in consultation with our members, reviewed this first regulatory proposal, and the following comments reflect our concerns, confusion and contempt of the process that has been employed thus far.

We hope these comments will be addressed, so that hundreds of thousands of vulnerable seniors, as well as the healthcare heroes who have sworn to protect them, will be heard.

TRANSPARENCY, PROCESS AND ANALYSIS

To be clear: the process that was utilized to formulate and update this first phase of the nursing facility licensure regulations has been, upon our review, both disheartening and downright shameful.

At one time, our association was included as part of a regulatory workgroup, which was tasked with making recommendations and providing input on new, proposed regulatory changes. We were encouraged by the initial conversation, the sharing of ideas, and the collaborative process. Though not every stakeholder necessarily agreed, the shared dialogue yielded a clear path forward on how we could update the nursing facility regulations, while also ensuring providers and advocates would be considered.

That was 2018.

The workgroup has since been disbanded. During some of the final conversation amongst its members, it was understood that the workgroup would be reconvened when the amended regulations could be shared for review. That, unfortunately, never took place.

Ultimately, we learned of the first phase of the regulatory proposal at the same time as the general population: July 21, 2021.

Why?

Why not bring stakeholders back to the table to review this proposal, and comment on its feasibility? Why not ask those on the frontlines of the COVID-19 pandemic to share existing workforce-related challenges? Why try, as COVID-19 case counts begin to rise again in Pennsylvania, to push a proposal forward as the entire industry looks to reform and adapt to a rapidly changing environment?

These questions, unfortunately, are still without answers.

The process to develop this initial regulatory change is entirely inconsistent with the objectives set forth in the Regulatory Review Act and Governor Tom Ridge's Executive Order (1996-1). Additionally, the decision by the Department of Health to introduce their proposed regulatory amendments in five separate, distinct packages is baffling, especially to one of the most-regulated industries in the entire country.

In order for long-term care providers to weigh the true impact of the proposed regulatory changes, it is imperative that the Department of Health release a comprehensive regulatory package for review. As with any regulatory chapter, different sections of the regulation are interconnected, and this current process will make it nearly impossible to understand the amendments in totality.

If the Department of Health insists on moving forward with this scattered, ill-advised process, we would recommend that, subsequent to the publication of all five individual regulatory packages, **a comprehensive regulatory package be published and subject to a 30-day comment period**, so that

stakeholders have the opportunity to learn how the different components and changes fit together.

The current process is akin to a film director releasing his or her ninety-minute movie in fifteen-minute increments. How can a critic possibly levy an opinion on the entire project?

Further, the Department has not given adequate attention to, nor has it fully addressed, the financial and economic impact of this proposed regulation on small businesses – a categorization that fits many PHCA members. Nursing homes are often major employers and purchasers in their communities, and long-term care continues to be an economic driver throughout Pennsylvania.

Simply stating that "the proposed regulations will apply to all 689 licensed long-term care nursing facilities in the Commonwealth" is not an analysis.

So, we've conducted a brief analysis of our own: in recent months, there has been an acceleration of sales, reorganizations, and changes of ownership among nursing homes, due largely to the economic challenges facing the industry. Years of inadequate Medicaid funding, coupled with skyrocketing pandemic-related costs and workforce shortages, have forced many of our members to the brink of collapse.

In just the last few weeks, nursing homes have been forced to halt new admissions due to lack of available staff. Some providers have closed entire wings and/or floors of their facilities. This is a troubling and dangerous trend, and desperate actions like these would only become more prevalent throughout the commonwealth if an increased minimum staffing requirement were to be imposed.

Not only is this an **access to care** issue in one of the oldest states, in terms of population, in the entire country, but closing entire floors and denying admissions would certainly impact the operating margin for any nursing home provider. Operating margins which, before the pandemic, were fixed at **-2.4%** for most providers and operators. Where was this consideration in the Department's small business analysis?

AN UNATTAINABLE MINIMUM: THE WORKFORCE CHALLENGES FACING LONG-TERM CARE

At the heart of the Department of Health's proposal is the increase in minimum staffing levels in nursing homes. This initiative comes at a time when providers are attempting to emerge from the COVID-19 pandemic, while also combatting the greatest workforce shortage in the history of the sector.

On its face, this proposal is simply unattainable. The Department of Health has, quite simply, ignored the alarming reality facing every single nursing home in Pennsylvania. Nearly every day, we hear from providers who are attempting, unsuccessfully, to fill vacancies and hire new staff. Those same providers have been forced to rely on agency, contract, or temporary staff to fill the void in shifts. While this is not only expensive and contrary to the idea of 'continuity of care', even staffing agencies are telling our members they don't have enough workers available. What is a provider to do if the workforce simply does not exist?

Currently, PHCA member facilities are reporting, on average, four RN vacancies, eight LPN vacancies, and eighteen nursing assistant vacancies. Raising direct care hours to 4.1 PPD will only add to the number of staff positions a nursing home will have to fill.

If the 4.1 requirement is implemented, we must ask: Where will this new workforce come from, and what programs and strategies will the Department implement to help us build our workforce?

AN UNFUNDED MANDATE

As with any proposed mandate, there is an accompanying cost to providers. In the preamble of the regulation, the Department states, based on an analysis from the Department of Human Services, that the additional cost to nursing homes participating in the Medical Assistance (Medicaid) program will be **$385.7 million**. In fiscal year 2022, $203.2 million would be paid by the federal government, and the remaining cost to DHS – or the providers we represent – would be approximately $182.5 million.

What the analysis fails to consider is the ongoing cost of this staffing requirement. To be clear: this is not a one-time expense for nursing homes. This requirement will need to be funded, year after year. Is the Department of Human Services committed to working with the Governor and members of the General assembly to provide this funding – which will be borne by the state's Medicaid program – to nursing homes? Currently, PHCA members rely on Medicaid to pay for most of the care they deliver. Without a substantial increase in funding, nursing home providers will **not** have the resources to cover the cost of additional staff.

In addition, the state's Medicaid program has failed to keep pace with rising costs for the better part of the past decade. Since 2014, Medicaid rates in Pennsylvania have remained stagnant, while health care costs rise, on average, 2.5% each year. Nursing facilities in Pennsylvania are also reimbursed, on average, at 80% of the true cost of care for their Medicaid residents (according to the state's own Case-Mix system). This has created a shortfall of nearly $50 per Medicaid resident per day.

Even before the onset of the COVID-19 pandemic, nursing home providers would have experienced great difficulty in raising staffing minimums from 2.7 to 4.1 PPD. Compounded with continuing, skyrocketing pandemic-related costs, the Medicaid shortfall has forced providers to do more and more with less and less.

Throughout the past eighteen months, PHCA has worked with leaders in the General Assembly, as well as Governor Wolf, to secure emergency, one-time funding for nursing homes from federal stimulus funds (the CARES Act in 2020, and the American Rescue Plan (ARP) in 2021). Those funds were allocated to address COVID-related expenses and cannot be utilized to supplement insufficient Medicaid funding – or increases in a minimum staffing requirement.

Given these glaring reimbursement shortfalls and disparities, how will providers possibly be equipped to cover the cost of this new mandate?

CONCERNS REGARDING SPECIFIC AMENDMENTS

In addition to the current workforce crisis and cost of this proposal, we have serious concerns regarding some of the amendments proposed in the rulemaking, as outlined below:

Incorporation of State Operations Manual: Although we support the incorporation by reference of the federal rules contained in 42 CFR 483, Subpart B (relating to requirements for long-term care facilities), we do **not** support the incorporation by reference of the State Operations Manual (SOM), Chapter 7 and Appendix PP – *Guidance to Surveyors for Long-Term Care Facilities*.

The State Operations Manual is not necessarily regulation, but it does offer guidance and interpretation to nursing facility surveyors. The information contained in the SOM can be changed by CMS at any time without notice or public input. Simply put: incorporating the SOM by reference circumvents the regulatory review process, and this would essentially delegate the ability to make any and all regulations for Pennsylvania nursing homes – without notice or comment opportunities – to CMS.

The regulatory review process was developed to ensure that the regulations drafted by different agencies are in the public interest, based on the following criteria: statutory authority and legislative intent; economic or fiscal impact; protection of the public health, safety and welfare; feasibility, clarity and reasonableness; and impact on small businesses. Moreover, CMS explicitly states in their S&C Memo, dated January 18, 2008, S&C-08-10, the following:

"Surveyors should refer to SOM Section 2712 "Use of Survey Protocols in the Survey Process" and Principle #5 in the Principles of Documentation found in Exhibit 7A for clarification in using information found in the interpretive guidelines. Both sources make it clear that surveyors must base all cited deficiencies on a violation of statutory and/or regulatory requirements, rather than sections of the interpretive guidelines. The deficiency citation must be written to explain how the entity fails to comply with the regulatory requirements, not how the facility fails to comply with the guidelines for the interpretation of those requirements."

For these reasons, it is our recommendation that the Department remove the incorporated references to the SOM.

§211.12 (relating to nursing services): First, when defining the term "during each shift", does this mean a nursing home will be required to provide, during each shift, a total of 4.1 hours of direct care to each resident? This clarification is important to fully understand the implication of this provision.

Given that we have not been able to obtain clarification on this definition, our comments assume that the increase to 4.1 will be applied in the same manner the 2.7 requirement has historically been determined. With that assumption in mind, this dramatic increase is of grave concern. If our assumption is inaccurate, and the intent is to require 4.1 hours of direct care to each resident during each shift, our concerns would be magnified.

First and foremost, any framework used to develop a new minimum hourly requirement for direct resident care must be based on objective analysis of current staffing levels, resident outcomes, the costs of meeting the standard, the definition of "direct care staff", staff competencies and workforce availability.

Currently, very few facilities are staffing at the 4.1 nursing hours minimum. Of the 414 nursing homes with publicly available PBJ data for January 2020, only 35 nursing facilities staffed at 4.1 nursing hours per resident each day of the month. In 2019 Q4 PBJ data, only 30 out of 687 nursing facilities with public data staffed at 4.1 nursing hours per resident each day. The impact on the remaining 657 nursing homes must be fully understood and considered.

It is also important to recognize that the current nursing facility regulations and the proposed regulation fails to consider the direct care provided by all "direct care staff", such as physical, occupational and speech therapists, dieticians, activities staff, wound care nurses and social workers. For many of the residents our providers care for today, a significant portion of their care is being provided by these

disciplines. Including the services provided by these “direct care staff” would align with the federal definition of “direct care staff”.

PHCA recommends that any minimum requirement of direct care hours include and recognize the contribution of all staff who provide direct care to nursing home residents.

On page 21 of the RAF (item number 26), the Department noted it considered other increases in the number of direct care resident hours, but ultimately decided that the increase to 4.1 hours represents the least burdensome acceptable alternative when weighed against the health and safety of residents in nursing facilities. We would like to understand what other alternatives were considered that led to the conclusion that the increase to 4.1 is the least burdensome acceptable alternative.

Furthermore, where is the irrefutable evidence that increasing the minimum standard will inherently improve quality of care? Judging the quality of care provided by a nursing facility based solely on staffing is misguided.

As part of our PHCA Quality Initiatives, we’ve examined this relationship: based on 2019 data, we compared Payroll-Based Journal nursing staffing data to eight quality measure scores, including: short-stay residents who were re-hospitalized after a nursing home admission; the number of hospitalizations per 1,000 long-stay resident days; long-stay residents whose need for help with daily activities has increased; long-stay residents who lose too much weight; long-stay residents who have depressive symptoms; long-stay residents experiencing one or more falls with major injury; long-stay residents whose ability to move independently worsened; and high risk long-stay residents with pressure ulcers.

After reviewing the data, we determined there wasn’t a strong (or even moderate) correlation between nurse staffing hours per resident day and higher scores for any of our quality initiatives, which would evidence that increasing the nurse staffing minimum hours per resident per day would not automatically lead to improved quality outcomes.

This is consistent at the federal level as well. CMS, in its most recent update of the federal nursing facility regulations, noted that staffing is a complicated issue, and that “one size fits all” is not the best approach.

For that reason, CMS developed tools and mechanisms, such as the facility assessment process, for nursing facilities to use to methodically assess the level of staffing needed to provide quality care to the residents they serve. The federal rule requires nursing facilities to conduct, document and review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. The facility assessment is used to assess if the facility has appropriately considered census and resident acuity to determine the number and competency of staff to meet each resident’s needs.

Additionally, under the federal regulation and during a survey, surveyors determine through information obtained by observations and interviews whether a nursing facility is effectively staffed to provide care and services to ensure residents attain and maintain their highest practicable level of physical, mental, functional, and psychosocial well-being. Through this process, if the surveyor determines the staffing level and/or competencies are inadequate, the Department of Health has the authority to require the facility to increase staffing to the level they perceive to be necessary.

Over the past four years, Pennsylvania's nursing facilities have only been cited, on average, twenty-six times each year for insufficient staffing. This represents only three percent of all providers.

CONCLUSION

Once again, the Pennsylvania Health Care Association has been proud to represent and advocate for nursing homes and long-term care facilities throughout the commonwealth – especially during the COVID-19 pandemic. The caregivers we represent are truly healthcare heroes, and we will continue to fight for support on their behalf.

As we look to the future, Pennsylvania's long-term care sector is faced with an unfortunate reality: rising costs, workforce shortages, and a population that is rapidly aging each day. That reality must be considered before any regulatory proposal can move forward. This initiative, in its current form, is both unrealistic and unattainable.

The Department must bring stakeholders and industry experts back to the table, so that we can develop a plan that works for our providers, caregivers, and residents.

If this regulation is implemented, it could limit access to care for hundreds of thousands of vulnerable seniors, drain resources and limited funding from providers, and force the closure of essential nursing homes throughout the commonwealth.

We cannot allow that to happen.

PHCA and our members are dedicated to protecting our most vulnerable citizens, and we implore the Department of Health to help – not hinder – this mission. Together, we can make a difference and improve the lives of our residents.

Thank you for the opportunity to share these concerns, and we look forward to working with the Department of Health to address this proposed regulation.

If you have any questions, please reach out to me at 717-221-7925 or zshamberg@phca.org.

Sincerely,

Zach Shamberg
President & CEO