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PACAH
Pennsylvania Coalition of Affiliated Healthcare & Living Communities

An affiliate of the County Commissioners Association of Pennsylvania

June 14, 2022

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Independent Regulatory Review Commission

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333 Market Street
14th Floor
Harrisburg, PA 17101

RE: Rulemakings 10-221 (Long-Term Care Facilities, Proposed Rulemaking Part 4)

To Whom It May Concern:

PACAH is an affiliate of the County Commissioners Association of Pennsylvania, and a leading advocate for all long-term care facilities in the Commonwealth. Our members care for one of the most vulnerable populations. PACAH members have been the safety net for many counties in Pennsylvania, delivering a level of access to care that other facilities may not provide. This is even more true in the current environment. PACAH members have faced extreme challenges in caring for their residents, and we are grateful for the continued support and attention the Pennsylvania Department of Health ("DOH") has provided.

It is PACAH's intention to communicate to DOH serious concerns related to Part 4 of the proposed regulations to amend existing statutes for long-term care facilities, which were published for comment on June 1, 2022.

I. Inconsistences with Federal Law

Throughout the 32-page proposed regulation, DOH states approximately fifty (50) times that certain changes to the regulations were to "eliminate duplication and avoid conflict with the Federal Requirements." Yet, DOH proposes to diverge from this proposed intent of avoiding conflict by specifically proposing a minimum number of direct care hours that must be provided to residents as well as the minimum number and type of nursing personnel for resident care.

DOH proposes to require a minimum of six (6) Nurse Aides ("NA"), two (2) Registered Nurses ("RN"), and one (1) Licensed Practical Nurse ("LPN") during the day shift for every 60 residents, six (6) NA, one (1) RN, and one (1) LPN during the evening shift for every 60 residents, and six (6) NA, and one (1) RN during the night for every 60 residents. This requirement is based on a 2001 study conducted by Marvin Feuerberg on Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. This study stated that there were incremental benefits in the increased staffing up to a certain threshold before no more benefit was achieved. DOH references these threshold as one of the main determining factors in establishing the 4.1 staffing

ratio as well as the specifically proposed number and type of personnel required for resident care. However, DOH reference of this report is wrong.

The 2001 report states that the threshold of incremental benefit is a range per nursing personnel type and depends primarily on the nursing home population. The study states that the threshold ranges include "2.4-2.8, 1.15-1.30, and 0.55-0.75 hrs/resident day for nurse aides, licensed staff (RNs and LPNs combined), and Registered Nurses, respectively." Feuerberg, Marvin. CMS. (December 2001). *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Overview of Phase II Report: Background, Study Approach, Findings, and Conclusions.* Yet, the DOH states that the minimum threshold is 2.8 hrs/resident for nurse aides, .75 for RNs, and .55 for "other licensed staff, that is, LPNs." In all, rather than the DOH following the 2001 CMS study and base quality thresholds on nursing home populations, their proposal uses thresholds that are not only inconsiderate to nursing homes' specific circumstances but are inaccurately referenced based on the reliance of the CMS study.

PACAH recommends that DOH issue new guidance that bases their hrs/resident quality thresholds on a range that is directly related to the specific nursing home's population without reference to specific personnel types or numbers. This will ensure that each nursing facility's circumstances are taken into consideration, and nursing home regulations align with the clear intent of DOH to "avoid conflict" with federal regulations.

II. Scope of Staff Ratios and Definition of Health Care Personnel

PACAH understands DOH's reasoning for amending § 211.12 §§ (i.1). However, DOH's reasoning is flawed if they are intent on relying on the 2001 CMS report regarding Appropriateness of Minimum Nurse Staffing Ratios.

Federal regulation clearly states, as well as the DOH's proposed regulation, that direct care, under the requirements for direct care staffing, may be provided by additional individuals, including therapists. However, the DOH, again, proposes to diverge from their overall intent of avoiding conflict with federal law and "goes above and beyond" the federal requirements for direct care staffing by only allowing NAs, LPNs, and RNs to be considered as direct care workers when evaluating staffing ratios.

There are many reasons to consider why the federal requirements allow for additional individuals, like therapists, to be consider part of the direct care worker definition. One reason is these individuals' training. Physical therapists, occupational therapists, and other licensed health care individuals are highly qualified individuals with extensive knowledge on general care for residents. DOH may believe that facilities will try and supplant nursing training and care with these licensed therapists to undercut the staffing ratios. This belief is under the assumption that these additional individuals or facilities will take it upon themselves to provide medical treatment that is outside the scope of their license. In reality, this would be a violation of their license and subject them to disciplinary action. In addition, services provided by nurse aides, as

mentioned in the 2001 CMS report (e.g. grooming independence enhancement, feeding assistance, etc.) are services that any trained licensed health care worker is able to provide. To not allow licensed therapist to be included in the health care worker definition is offensive to the training of other licensed health care workers and completely in conflict with federal regulation.

One would imply the federal government took this into consideration when developing their definition and scope of staff ratios when reviewing the 2001 CMS report. This report clearly states that implementation of the staffing ratio thresholds "would find 97 percent of all nursing homes failing to meet one or more of these standards." If the DOH does not wish to make 97% of all Pennsylvania nursing homes non-compliant with DOH regulations, they must allow for other health care workers to be included when calculating the staff ratios.

In addition, DOH's proposed regulation makes no reference to dual licensed health care workers. PACAH provides a number of services to its members and their health care staff (of all levels.) Many of these staff are dual licensed. Several Nursing Home Administrators (NHA) are former RNs. To imply that a dual licensed NHA is unable or not qualified to provide care or not fall under the definition of a direct care worker is, again, in direct conflict with federal regulations and failing to see additional avenues of efficient and superior care.

PACAH recommends that DOH following the federal definition of direct care staffing by allowing other licensed health care workers to be considered under the staffing ratio and provide other avenues for other licensed health care workers to provide care. This will allow for facilities to meet the new standards and provide a level of care that residents should receive.

III. Cost and Assumptions for Regulation Compliance

While PACAH holds itself as a representative for all long-term care facilities in Pennsylvania, PACAH concentrates on ensuring that the most vulnerable of long-term care residents are provided for. Thus, PACAH's primary purpose is to ensure county homes and veteran's homes are provided services that improve care for their residents. These facilities consistently have a higher percentage of Medicaid residents than other private facilities and, thus, face a greater hurdle when it comes to costs and regulation compliance.

DOH states that of the 20 county-owned facilities that provided nursing home care, 184 full time RNs would be needed to comply with the proposed regulations. This would result in a 28% increase from the current cost report data or an average cost of $127,072 for each RN. This equates to an overall cost of $23,381,248 to the 20 counties that currently own nursing homes.

In addition, DOH projects that the county homes would also need to hire approximately 539 nurse aides to meet compliance. This would result in a 23% increase from the current cost report data or an average cost of $56,477 for each NA. This equates to an overall cost of $30,441,103. Overall, the cost of compliance for county nursing homes would equate to $53,822,351.

While the DOH states that 84.51 percent of this cost would be covered by the Medical Assistance program, there is no real discussion on how county homes are supposed to find the extra 15.49 percent or $8,337,082 to meet compliance, and this is under the assumption that the facilities are able to hire the additional 723 staff needed.

Also, DOH projects that of the 6 veterans' homes in Pennsylvania, 43 NAs, 166 full-time RNs and 83 LPNs would be needed to comply with the proposed regulations. This would result in an additional $34,452,469.07 in funding. DOH projects that of the number of eligible MA residents in these homes, the MA program would cover approximately $12 million of the additional cost. This results in an overall increase in state funding of $22.2 million. Thus, the DOH is proposing regulations on the assumption that the state legislator will provide the additional funds for compliance, assuming, again, that there are enough licensed professional to hire.

PACAH recommends that the DOH develop programs to increase the number of licensed NAs, LPNs, and RNs as well as secure the additional funding needed before moving forward with the increased staffing ratio. Without doing so, the DOH is placing all county and veterans' homes in threat of non-compliant with DOH regulations and to remain non-compliant permanently.

Overall, the divergence from federal definitions and regulations, broad assumptions, and lack of consideration by DOH could lead to disastrous effects for many long-term care facilities, reducing the number of beds they service or, ultimately, closing the facility altogether. As the elder population continues to grow, it is inconceivable what would happen to those who will not receive the care they need solely due to the regulatory requirements that cause the number of available facilities to close forever.

We thank you for your attention to these comments. If you have any questions or would like to discuss further, please do not hesitate to contact me at ccannon@pacounties.org.

Sincerely,

Chase Cannon

Chase Cannon
Executive Director
Pennsylvania Coalition of Affiliated Health Care & Living Communities