LeadingAge PA

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

June 24, 2022

Dear Ms. Gutierrez:

LeadingAge PA, an association representing more than 370 mission-driven providers of senior services, appreciates the opportunity to offer comments on proposed Rulemaking 10-224 (Long-Term Care Facilities, Proposed Rulemaking 4) as published in the May 28, 2022, *Pennsylvania Bulletin*.

To put our comments into context, we must first address the environment that surrounds the proposed rule: a global pandemic, a workforce crisis, and extremely difficult financial conditions. While facing these challenges, many high-quality nursing homes are contemplating or already taking action towards reducing the number of residents they serve or total closure of their buildings. In March, LeadingAge PA surveyed our membership to understand to what extent members are being forced to take beds "offline" and limit capacity. Survey participants reported a four-fold increase in the number of beds taken offline between 2019-2021, with the top reasons being inadequate staffing (RN/LPN and nurse aides) and inadequate Medicaid reimbursement. The proposed rule comes during a time of uncertainty when nursing home providers continue to battle a pandemic during the midst of the most critical workforce shortage they have ever seen, while continuing to face significant Medicaid funding gaps.

Our comments center on the following primary themes:

- The workforce in Pennsylvania does not exist.
- The 4.1 staffing threshold and associated nursing ratios are unattainable and do not directly guarantee quality outcomes.
- The proposed changes would require significant planning, budgeting, and hiring decisions on the part of the regulated community.
- DOH must improve coordination with federal initiatives.
- Prescriptive staffing ratios, if adopted, require thoughtful enforcement strategies, appropriate flexibility, consultation with stakeholders, and time for nursing facilities to plan and implement, especially during the current cross-sector workforce crisis.

- The Department of Health's (DOH's) review of the fiscal impact on facilities lacks meaningful analysis of costs on the regulated community and ignores the potential impacts on small businesses and on individuals who require nursing home care.
- Release of the regulatory package in sections lacks reasonableness, transparency, and clarity.
- Stakeholder negotiation with DOH and the administration to make the staffing increases financially feasible on an ongoing basis will be key to industry support for increased staffing minimums.
- The path forward to improving quality and access to care for older Pennsylvanians will need to include continued collaboration between state government and industry partners

In addition to the general themes noted above, LeadingAge PA has comments on several specific proposed regulatory changes, which we will turn to first.

In various sections of 201.18, terms and/or phrases are used that are not well defined and could be interpreted differently by different surveyors. Examples include:

- 201.18(d.1)(4) The director of nursing services has adequate knowledge and experience to compensate for the time the administrator is not in the building. What is meant by "adequate knowledge and experience" and how will that determination be made?
- 201.18(d.2) The administrator's schedule shall be publicly posted in the facility. Does this mean their normal work schedule, or must the schedule be adjusted if the administrator calls out sick or is out of the building for a meeting, education, etc.? LeadingAge PA asks that this requirement be changed to read the "administrator's normal work schedule."
- 201.18(e) (2.1) Ensuring satisfactory housekeeping in the facility and maintenance of the building and grounds. What is meant by "satisfactory" housekeeping? This could be widely interpreted based on an individual's personal standards.

In 201.18(h) we would recommend that the DOH add the term "business," so that the sentence reads: "The facility shall provide cash, if requested, within one BUSINESS day of the request or a check, if requested, within three BUSINESS days of the request." In order to safeguard resident cash, most facilities do not have ATM cards or availability to obtain cash except on days that banks are open. LeadingAge PA requests that this requirement be modified so it meets banking schedules.

201.19 (9) would require, in the event of a conviction prior to or following employment, a determination by the facility of an employee's suitability for initial or continued employment in the position to which the employee is assigned. LeadingAge PA has been involved with discussions with both the Wolf Administration and the General Assembly on modification to the Older Adults Protective Services Act (OAPSA) since the Pennsylvania Commonwealth Court decision in *Peake v. Commonwealth of Pennsylvania, et al., 216 M.D. 2015.* To mandate information regarding criminal convictions seems to be mandating a change to law thus circumventing the regulatory process perhaps because the administration has not been successful in negotiating either with the General Assembly or stakeholders. Further, after the Peake decision, the PA Department of Aging's advice to nursing facilities was to seek legal counsel if they chose to hire an individual with a criminal conviction. It seems troubling that DOH may be asking for information to be included in a personnel file that may be under attorney/client privilege.

201.24(e) would require written policies for the admissions process. These new requirements appear to be resident-centered and reasonable, however, it may be exhausting to the resident on the day they move to

their new home, often following a hospitalization or other serious health issue, to comply with the admissions process within two hours of their admission to the facility. LeadingAge PA would request that a resident or the resident representative be allowed to request that the orientation and discussion components be deferred to a later time within the next 24 hours, if they prefer, without the facility being cited for respecting the resident's preferences. The initial introduction of residents to at least one member of the professional nursing staff for the unit would be reasonable to occur within the first two hours after admission, but it may be appropriate for the resident to rest, visit with family, get acclimated to their surroundings before being required to take in all of the proposed additional admissions information and activities.

The 201.29 Resident Rights section in general streamlines and clarifies the requirements by deferring to federal resident rights, which are extensive. There is an addition of 201.29 (p), however, which is unnecessary since it is, with one exception, a duplication of the Pennsylvania Human Rights Act protections for all Pennsylvania citizens, and federally for clients of health care entities that receive federal funding through Section 1557 of the Patient Protection and Affordable Care Act.

The change in section 211.3 Verbal and telephone orders. (b) regarding the timeframe to sign a verbal order seems unreasonable. The current language is 7 days, the new language 48 hours. Even by allowing physician delegates, the commonwealth does not have enough medical personnel to care for the citizens, rendering this change unreasonable especially since there is seemingly no data to show that the current regulation is not sufficient.

LeadingAge PA now turns to the general themes of our comments, beginning with the current workforce crisis.

The workforce in Pennsylvania does not exist.

The workforce crisis is the single largest threat to our nursing facilities' ability to offer quality care at the capacities they are designed to serve. Given the decrease in the working age population, nursing facilities are already having an exceedingly challenging time hiring the staff they need to provide excellent care. A mandated level of staffing will put additional pressure on nursing facilities to find and hire people who do not exist in the labor pool. To recruit new staff, senior service providers are forced to offer a competitive compensation to attract candidates, in a time where candidates could receive higher compensation or more flexible hours in a different industry. In return, this causes wage compression to occur because newly hired staff are offered a higher pay and, in most cases, receive a higher compensation than those who have worked in the industry for many years, which then presents a retention issue. Additionally, the labor shortage is causing long-term care providers to reduce the number of individuals they can serve and halting new admissions to those who need the care the most. Considering the vacant staff positions and no one to fill them, proposing to increase mandatory staffing minimums to 4.1 nursing hours per patient day and associated ratios is an unrealistic requirement that nursing facilities will struggle to meet.

The 4.1 staffing threshold and associated nursing ratios are unattainable and do not directly guarantee quality outcomes.

LeadingAge PA believes the best approach to staffing is based, as it is currently in the federal regulations, on resident care plans, staff competency, and a facility assessment that matches the needs of the residents to the capabilities of the staff, as well as characteristics of the building that may impact staffing needs.

When considering operational concerns, LeadingAge PA urges the DOH to recognize that specific staffing thresholds do not directly guarantee quality outcomes. Enforcing mandatory staffing minimums may not have the anticipated impact of enhancing the quality of care. In fact, there are intangible variables that are not accounted for when looking at the correlation between staffing and quality care, such as investment in staff training, staff tenure, management, and facility culture. Additionally, each nursing home has unique features including acuity of residents, staff training, competency, and tenure, and physical layout characteristics of the facility. Some facilities have subacute units or areas of their building that require higher staffing but these same buildings may have units or areas that have residents who may need more activities programming and less nursing care. We urge the Department to grant the nursing facilities the utmost flexibility in complying with staffing thresholds and ratios so that residents receive the care and services they need rather than being forced to meet arbitrary regulatory mandates.

Further, quality of life and resident well-being is often defined by residents as a function of adequate clinical care coupled with exceptional person-centered programming like music, therapies, games, meals, and other social activities. LeadingAge PA appreciates and supports the DOH's proposal in 211.12 Nursing Services, to allow a facility to substitute an LPN or RN for a nurse aide, or an RN for an LPN position, however, we would request that DOH add other staff in the minimum staffing thresholds, such as physical therapists, occupational therapists, speech therapists, social workers, and activities professionals, since these professionals are important to the residents' quality of life and well-being. We would therefore strongly urge striking the proposed addition at 211.12 (i.1) that states "Only Direct resident care provided by nursing service personnel shall be counted towards the total number of hours of general nursing care required under subsection (i)." We further believe that the public health, safety, and welfare may be better protected by expanding the definition of direct care staff to align with the Federal definition.

Not only do mandatory staffing minimums present their own challenges, but they would further exacerbate the workforce shortage. Staffing ratios, however well-intentioned, may have a negative impact on resident care by imposing the need for more staff than can be recruited, which will likely be filled by contract or agency staff. Many nursing facilities have no choice but to contract with staffing agencies to meet current minimum standards, but if the proposed staffing ratios are implemented, facilities would have further need to utilize staffing agencies to meet these requirements. As competition and demand increases, staffing agencies across the nation have been able to increase prices, and captive facilities have been left with no options but to pay rates that could easily be deemed price gouging. This is not sustainable for our senior service providers who have been left with limited options– close, sell, or limit capacity. Furthermore, the quality of care delivered by agency staff is typically lower than that of longer standing, well tenured staff. It is not a criticism of the quality of individual staff, but an observation that agency staff are often not as aware of resident preferences and needs as dedicated facility staff are.

The proposed changes would require significant planning, budgeting, and hiring decisions on the part of the regulated community.

The proposed regulations not only set an unfeasible minimum threshold of 4.1 nursing hours per patient day, with prescriptive staffing ratios per shift, they would require implementation immediately upon publication in the *Pennsylvania* Bulletin. Any mandatory staffing minimums would require time and planning to attempt to meet the new requirements. Nursing facilities and their administrations would need time to budget, plan for, hire, and train the additional staff needed to help meet mandatory staffing requirements if they are included in a final regulation package. LeadingAge PA strongly urges that DOH carefully consider the amount of planning and time that it will take for nursing facilities to be compliant with mandatory staffing minimums

and offer effective dates no earlier than 18 months after the publication of the final regulations. Further, LeadingAge PA would urge the DOH to ramp up staffing increases over a period of at least two years after the effective date, to give providers a chance to recruit and make budget changes to support proposed increases in staffing.

DOH must improve coordination with federal initiatives.

LeadingAge PA thanks the DOH for its proposal to eliminate sections of regulations that are duplicative of federal regulations, which we believe will generally clarify and streamline the survey process. LeadingAge PA is concerned, however, with the DOH's lack of coordination with current federal nursing facility initiatives. For example, the Biden Administration announced on February 28, 2022, that the Centers for Medicare and Medicaid Services (CMS) is launching several new proposals that it believes will improve the quality of care in nursing homes. The White House announcement states: "CMS intends to propose minimum standards for staffing adequacy that nursing homes must meet. CMS will conduct a new research study to determine the level and type of staffing needed to ensure safe and quality care and will issue proposed rules within one year."[1] LeadingAge observes that it would seem prudent for DOH to await action by CMS prior to the adoption of any additional state requirements, rather than to forge ahead with its own staffing minimum standards. Finally, we note that, while the DOH is eliminating duplicative requirements, it also proposes several that are more stringent than federal requirements such as the proposed requirement for nursing homes with fewer than 120 licensed beds to have a full-time social worker and the proposal to impose a specific staffing minimum and ratios.

Prescriptive staffing ratios, if adopted, require thoughtful enforcement strategies, consultation with stakeholders, and time for nursing facilities to plan and implement, especially during the current cross-sector workforce crisis.

If mandatory staffing minimums are increased, it is essential to assure adequate, ongoing funding to support the effort. It is also imperative to allow sufficient flexibility to mitigate punitive action against facilities that are typically compliant or demonstrate significant effort towards compliance. Meeting the proposed increase in staffing minimums in the current labor environment will be nearly impossible for many providers. The proposed prescriptive staffing ratios, with requirements for each shift that do not consider the needs or preferences of residents, nor the availability, needs, or preferences of staff, present a substantial risk that nursing facilities will not be able to meet these requirements no matter how hard they try. It is unlikely that the workforce crisis we are experiencing will improve any time soon – and it is likely to worsen as the demographics continue to shift toward more older adults and fewer people of working age. Therefore, it is important to discuss how DOH will determine compliance and sanction noncompliance if it continues to adopt the proposed staffing requirements.

To be clear, the proposed 4.1 minimum staffing threshold and the nursing ratios proposed in these regulations are not feasible or reasonable. LeadingAge PA cannot support the nursing staff proposals as stated in the proposed regulations. If staffing ratio requirements are adopted - and we would request that if DOH moves forward with these proposals, they attempt to mitigate the harm by considering much more reasonable staffing targets than have been proposed - LeadingAge PA would respectfully request that the determination of compliance with staffing requirements offer flexibility that recognizes the serious workforce

[1] https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/ accessed June 19, 2022.

crisis that faces nursing facility providers and the difficulty of meeting any additional staff coverage requirements. Again, we reiterate that even additional flexibility will not make the proposed staffing ratios and the staffing minimum threshold feasible but would provide much-needed flexibility in the current environment and would certainly be necessary if staffing levels and staffing ratios are increased. This flexibility would allow the nursing facility to adjust to call-offs, staff illnesses, or weather emergencies that are beyond their control. Additional factors that could be considered would include demonstrated efforts to recruit the personnel in question, steps implemented to assure resident well-being such as changing the deployment of staff to assure resident needs are met, and observations that residents are receiving the services necessary to attain or maintain their physical, mental, and psychosocial well-being at the highest practicable level. DOH should allow some flexibility in meeting any staffing requirements, not only in recognition of the staffing crisis, but also so that staffing can respond to resident needs and preferences, which may not always align with the proposed ratios.

Given the anticipated difficulties in meeting the proposed staffing minimums and ratios, these regulations are highly likely to subject nursing facilities to citations and fines. Such enforcement actions would dissipate the funds needed to care for residents, which is an unintended outcome that would not improve care. The DOH should thoughtfully consider the workforce crisis and work with stakeholders to mitigate the impact of enforcement actions and sanctions that are based on inability to recruit an adequate supply of workers to assure that Medicaid and private dollars intended for use at the bedside are not re-directed to cover punitive fines to the detriment of nursing home residents.

LeadingAge PA has many serious concerns about this proposal. For example, prescriptive ratios are especially dangerous for facilities near ratio cut points. Many high-quality facilities would be forced to limit admissions based on their available staff. The ongoing struggles for nursing homes to compete with acute care settings for skilled and clinical staff remain front of mind for many members. An inability to admit additional residents because of overly prescriptive staffing ratios causes a cyclical problem of reducing available revenue for the facility for post-acute rehabilitation services. Ongoing inability to admit will cause individuals to remain in hospitals for longer than is needed. While the department intends to increase quality by increasing staffing, the current proposal fails to understand the unintended consequences of limiting access as facilities are unable to hire or make decisions about their available capacity for Medicaid residents.

Small facilities will be disproportionately harmed by the imposition of the proposed ratios and addition of a social worker. These facilities have fewer residents and may have smaller budgets and fewer staff than larger facilities and the proposed lack of flexibility in staffing will make it much more difficult for them to comply.

LeadingAge PA respectfully requests that, if the DOH moves forward with proposed nursing staff increases, these requirements not begin at the proposed threshold but instead begin to increase over time, after facilities have had time to understand and budget for these changes. If the DOH continues in this direction, we request that it create a careful pathway during which the DOH meets at least quarterly with provider stakeholders including LeadingAge PA to allow the opportunity to gain input and make adjustments, as adverse outcomes are observed. Further, LeadingAge PA urges the DOH to recognize and assist in efforts to provide the significant ongoing increase in funding needed in the Medical Assistance (MA) Program to support the ongoing costs of this proposal and to assist in efforts to mitigate the ongoing costs to providers and residents that will not be supported by an MA increase. Finally, LeadingAge PA urges the DOH to carefully consider a more realistic minimum threshold than the proposed 4.1 nursing hours and associated staffing ratios and instead, propose a more attainable goal.

DOH's review of the fiscal impact on facilities lacks meaningful analysis of costs on the regulated community and ignores the potential impacts on small businesses and on elderly people who require nursing home care.

LeadingAge PA notes that, unlike the negligible attempts in the prior regulatory packages, the DOH has attempted to estimate some of the costs to nursing facilities to meet the proposals for increased staffing, and the proposed staffing ratios. LeadingAge PA commends the DOH for this effort, however, we note that the inflation rate is now more than 8 percent, as opposed to the 5 percent inflation rate used in the estimate and believes that it would be appropriate to update the estimate to reflect this more current rate. Additionally, we appreciate that the DOH has considered some of the increase in wages that will occur as all 689 nursing facilities begin recruiting already scarce RNs, LPNs, and nurse aides to attempt to meet the proposed requirements. As stated earlier, LeadingAge PA members in some areas of the Commonwealth are closing beds or wings, due to their inability to recruit and hire RNs, LPNs, or nurse aides at any salary, so it is not clear the factor used by DOH captures the true situation, but the attempt is appreciated. Finally, as nursing facilities compete to hire new staff, it will likely increase costs to retain current staff, creating pressure to increase wages and benefits of longtime staff. These cost increases are not included in the estimate.

As with the prior regulatory packages to change the nursing facility regulations, the DOH continues in this regulatory package to ignore the adverse impacts these proposed regulations will likely have on small businesses. Although IRRC requested that the DOH calculate and address the impact of the final-form regulation on small businesses as required under the Regulatory Review Act, the DOH still has not provided an identification and estimate of the number of small businesses subject to the proposed regulation. A cursory review by LeadingAge PA indicates that many nursing facilities would be considered small businesses, according to the Regulatory Review Act's definition, which references federal Small Business Administration's definitions of nursing facilities with annual revenue of less than $30 million. Except for the analysis regarding the proposed increases to nursing staff and the requirement that all nursing facilities regardless of size employ a full-time social worker, DOH has not attempted to estimate the regulatory burden on any of the regulated community, much less attempt to discern its impact on the many nursing homes that are considered small businesses.

Since the three license-only homes are small – one has 20 licensed beds, one has 30 and one has 52 - and likely to be considered small businesses, failing to consider the significant impact on these homes seems to be an especially egregious omission. DOH did not offer to estimate the economic impact of the potentially costly requirements that these license-only homes comply with all the federal regulations, stating instead that "…any effect on these three facilities is outweighed by the need for consistency in the application of standards to all long-term care nursing facilities, regardless of whether they participate in Medicare or MA." While convenient and certainly a worthy goal, consistency in application of standards does not seem to the be a necessity for protecting the public health, safety, and welfare.

DOH did estimate that the aggregate annual cost to these three small facilities to meet the proposed nurse staffing minimums and ratios would be $833,031 and the cost for full time social workers would be $36,608 for one home that has a part-time social worker and $73,216 for one home that has no social worker.

DOH's statement that its "responsibility to the quality of care to residents in long-term care nursing facilities applies to all of those residents and is not altered by the fact that a long-term care nursing facility may be considered a small business" does not sufficiently address the adverse impact of the proposal. In addition, please note that the new requirement for homes with less than 120 licensed beds to employ a full-time social

worker impacts only the smaller facilities that would likely be considered small businesses; according to DOH, ninety-one of these privately owned facilities would be affected since they do not currently employ a full-time social worker.

The Regulatory Review Act requires DOH to provide a description of any special provisions which have been developed to meet the particular needs of affected groups and persons, including minorities, the elderly, small businesses, and farmers. In addition to neglecting the requirement to address the impact on small businesses, the DOH has failed to address the potential access issues the proposal may have on individuals who need nursing facility care. The cost analysis for the proposed increased staffing attempts to address the impacts on the facility and the Medical Assistance Program but fails to note that a significant percentage of the costs will be borne by individual residents of nursing facilities who are paying privately for the services they need. The DOH claims that it cannot estimate the impact of the proposed regulations on these residents, nor can it estimate the impact on residents whose stay is covered by Medicare.

In the IRRC's comments on the initial nursing facility regulation (#10-221 IRRC #3312), IRRC supported LeadingAge PA's request for adequate calculations of the cost burdens, requesting that DOH work with the Department of Human Services (DHS) to provide additional information related to how the calculation was made that stated that the net cost of increasing staffing would only be $182.5 million in additional costs to the DHS, and to explain how this may impact residents in facilities that rely on Medical Assistance and residents in private-pay facilities. LeadingAge PA appreciates that DOH has included an estimate of the cost of worker benefits which it omitted in the #10-221 Regulatory Analysis Form, and has worked to estimate costs to county facilities, however, there continues to be no attempt to estimate the costs to private pay residents or residents with coverage other than Medicaid. LeadingAge PA would respectfully request that the DOH return to their estimate to provide a more complete analysis of the adverse financial impact it will have on the many residents who will need to pay out of pocket for the proposed required services such as a social worker and additional nursing staff. It is disingenuous for DOH to say that there is no way for them to estimate the financial impacts of their proposals on Medicare beneficiaries and their nursing facilities. There are many resources describing Medicare's Patient Driven Payment Model, considerable data available, and consultants and other experts who should be able to assist the DOH to estimate how much of the proposed increased staffing costs would be borne by the facility and individual residents. We note that DOH has not yet provided an estimate of the costs to hire and train staff or the effect on the Medical Assistance Program when private pay residents spend down more quickly due to the increased costs of the proposal.

Unless the administration provides ongoing increases to the Medical Assistance rates to support this proposal, the proposed nursing services requirements will compound existing business challenges. Workforce, inflation, and wage compression are already hobbling efforts to rebuild census and support full nursing home capacity. Proposed staffing changes would further increase pressure on nursing facilities to reduce capacity or close, which in turn will make it difficult as well as more costly for elderly people to access nursing facility care.

Release of regulatory packages in sections lacks reasonableness, transparency, and clarity.

The proposed rules are noted to be the fourth of the series of related rulemaking packages that DOH expects will eventually update the entirety of the current nursing facility regulations. Without view of the comprehensive package, neither the regulated community nor the public can assess the full scope of changes that may be promulgated as final. This could happen for any number of reasons; none more important than each package likely requiring individual approval by the Independent Regulatory Review Commission and

oversight committees in the General Assembly. This could result in incongruous enactment and confusion that will not further DOH's stated goals of improving the quality of care.

In its comments on the first set of DOH's proposed regulatory package, the Independent Regulatory Review Commission requested that the Department consider the significant concerns of the regulated community and the requests to withdraw this proposed regulation and move forward with one comprehensive regulation – or if it continues along this path of issuing separate regulatory packages, to explain why this approach is reasonable. Finally, IRRC requested that the Department ensure that the regulations and any amendments are consistent across the packages, and that the interrelation and any impacts between the packages are clearly presented for the regulated community. LeadingAge PA agrees with these comments and would respectfully request that DOH combine the regulatory packages into one coherent whole before publishing as proposed. Further, it is of utmost importance that DOH provide opportunity for public comment on proposed regulations as a whole prior to publishing as final. The regulated community and the public cannot anticipate how the changes to definitions, for example, will impact regulations that have been proposed but not yet finalized, nor can they understand how various portions of the regulations will interact with one another. It is reasonable and in the public interest that the nursing facility regulations receive public comment and enactment in a single regulatory package so that stakeholders have transparency and clarity on how the proposed regulations interact with one another. Even now, with each of the proposed regulatory packages published, it is not clear which provisions will be included in the final regulation if DOH makes changes based on public comment. In addition to providing the regulated community an opportunity to view and comment on these separate regulatory packages as one comprehensive proposed rule, we would request, as IRRC did in its comments, that DOH assure that the regulations are consistent across packages and that DOH clearly present to the regulated community the interrelation and any impacts between the packages.

Finally, the proposal anticipates implementation upon publication in the *Pennsylvania Bulletin*, which is not reasonable. Compliance with new regulations takes time to understand the required changes and will require planning to initiate the staffing and budget changes to achieve compliance. It is particularly unreasonable to assume that the license-only nursing facilities will be able to immediately implement copious federal regulations with which they need not currently comply. A period of at least 18 months is necessary to begin to implement the regulations, so that providers can understand the changes and make plans. Further, the proposed nursing staff increases should not begin at the proposed threshold but instead begin to ramp up over time, after facilities have had time to understand and budget for these changes. For example, with regards to staffing ratios, LeadingAge PA urges that if DOH continues along the path of increasing the minimum thresholds for nursing staff, it seek a recurring funding source to support these costs, proceed cautiously over several years, and seriously consider whether the proposed nursing staff threshold level of 4.1 is reasonable, attainable, and in the public interest, given the workforce crisis, the potential access issues it may create, and the costs that will be shouldered by nursing facilities and their residents.

There is a path forward to improving quality and access to care for older Pennsylvanians with continued collaboration between state government and industry partners

Ongoing stakeholder engagement will be crucial as any finalized regulations and sub-regulatory guidance is developed. LeadingAge PA requests that both providers and their associations be included in both the development of a final regulatory proposal that combines all four of the regulatory packages and subsequent sub-regulatory guidance to inform surveyors how to monitor compliance with the new package. The inclusion

of existing providers who understand the effects the regulation will have on their nursing homes will be key to DOH receiving effective feedback from the regulated community.

With a sufficient increase to Medicaid funding, LeadingAge PA can see a path forward to reasonable staffing requirements that will ensure access to quality nursing home care. This entails a $294.3 million increase to Medicaid nursing home rates in order to meet a year 1 facility-wide staffing requirement of 2.87 nursing hours per patient day (NHPPD)/associated ratios and additional commensurate funding to meet a year #2 and beyond facility-wide NHPPD of 3.2 and associated ratios. Key to this pathway is the inclusion of appropriate flexibility to meet new staffing requirements that recognizes the immense challenges of the workforce crisis and the operational implications of ensuring access to quality care.

The members and staff of LeadingAge PA are always ready to assist you with any issues or questions relating to caring for our seniors. We look forward to working with you so the Commonwealth's seniors have quality long-term care services and supports should they be needed.

Please feel free to contact me if you have any questions regarding these comments or if we can be a resource to the department.

Sincerely,

Garry Pezzano
President and CEO
LeadingAge PA