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California Department of Public Health
1615 Capitol Avenue, MS 3201
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VIA EMAIL AND U.S MAIL

RE: SB 97 (2017) implementation –Patient Needs/Acuity Waiver Stakeholder Meetings – CAHF Comments

The California Association of Health Facilities (CAHF) was invited to participate in two stakeholder meetings in July, 2018, primarily to discuss the Patient Needs (a.k.a. Patient Acuity) Waiver, which is required by SB 97. As a participant in these meetings, we are submitting the following written comments and concerns.

CAHF and its members continue to do everything we can to meet the 3.5/2.4 mandate, but this mandate will be a long-lasting impracticality for nursing facility providers and the State.

CAHF's skilled nursing facilities (SNFs) are doing everything possible to comply with the new 3.5/2.4 direct care service hours requirement included in SB 97. Both CAHF and its members are committed to being in compliance with the new mandate, however, without the available workforce to hire, SNFs are set up for failure. Even with the "phase-in" of administrative penalties, CAHF is aware of several providers who have limited their bed supply and occupancy level in order to meet the new mandate that went into effect on July 1, 2018. Access to skilled nursing care has already been reduced in response to SB 97. If not appropriately remedied, the overall negative effect of SB 97 will be felt for years to come.

While CAHF appreciates the important role of certified nursing assistants (CNAs) in providing care to patients, facilities that are above the 3.5 direct care service requirement should not be penalized for not meeting a 2.4 CNA staffing requirement only because they have more qualified, specialized and higher trained nursing staff on the floor (i.e. everything a CNA can do, an LVN or RN can do). It is without merit that LVNs and RNs cannot be counted to meet the 2.4 requirement, particularly when they are doing work that would normally be done by CNAs. It is completely within their scope, and many times, already their accustomed duty. It is already customary practice in many SNFs and hospitals that LVNs and RNs perform CNA functions when it is needed, and overall care and resident outcomes are not compromised. The facility and medical staff know who is best to care for their individual patient mix needs.

Lastly, we continue to pursue policy changes and funding opportunities that will assist facilities and programs to attract and train individuals as CNAs to help fill in vacant CNA positions throughout the state. We are also very appreciative of the money that was included in the 2018-19 State budget for training programs. Unfortunately, the reality is that the workforce shortage crisis will not be solved for many years – especially in light of California's low unemployment rate and competing workplace opportunities for direct caregivers.

Subacute facilities or units should be granted an automatic patient needs waiver

Subacute facilities or units already have strict licensed nurse staffing requirements that go above and beyond the requirements of SB 97. To change these minimums because of the arbitrary standards that were established in SB 97 would not only be detrimental to subacute facility staffing needs but also jeopardize patient care.

Patient needs waivers should be automatically renewed on an annual basis unless otherwise determined by DPH. There should not be a maximum amount of renewals.

More licensed and qualified staff in a building is a good thing – not bad. For example, a facility that has a ratio of 3.5/1.8 under the current regulations has more licensed and qualified staff on the floor than a facility with 3.5/2.4. The facility with the 1.8 CNA hours should not be penalized for having more licensed and qualified staff on the floor. Patient census and resident mix can change monthly, weekly and even daily, however, facilities that offer services to patients with higher acuity will continue to do so. As previously stated, everything a CNA does, an LVN and RN can do. Because of this reality, there is no reason for this waiver not to be automatically renewed on an annual basis unless a facility's patient care changes significantly or a facility's overall quality of care changes.

Any denial or revocation criteria that is currently in the Workforce Shortage Waiver is also improper for inclusion in the Patient Needs Waiver. As CAHF has stated before in previous stakeholder meetings, not only could the date of an adverse incident be up to several years old (i.e. an AA, A or G alleged incident could date back to 2013, but cited in 2017), it could also have been an isolated incident which does not portray the overall quality of care in the building. Recent estimates show that such automatic denial/revocation criteria would exclude 476 SNFs from obtaining a Patient Needs Waiver.

Any recommendation that "(t)he baseline requirement for SNFs to obtain a patient needs waiver under SB 97 should be that the majority (more than 50%) of their residents have documented higher acuity needs that require a higher ratio of licensed nurses to CNAs" is arbitrary and unreasonable. Not only would this unfairly limit the Patient Needs Waiver to an extremely small percentage of SNFs, it would also be discriminatory based upon uncontrollable payer mixes and CMS Research Utilization Groups (RUG) levels. There is no basis for such a recommendation and it is impractical and nearly impossible to comply with.

Any proposal to limit the number of patient needs waivers granted to a particular facility, would not be in the best interest of the resident, the health care continuum or the community. Over the years and prior to SB 97, SNFs throughout the state have made it a priority to recruit more licensed staff (i.e. LVNs, RNs) and therapists to appropriately care for their patient mix – not more CNAs. This is because SNFs are caring for more acute, complex and older residents, and there are more demands from health plans, hospitals and the federal government. This trend will only increase and more licensed staff will be required to meet the resident care plans and needs. Therefore, any limit on the number of patient needs waiver is not sensible and not in the best interest of quality skilled nursing facility care.

To suggest 3.5/2.4 is the "new floor for quality" is without a proper foundation. There has never been a federal standard, mandate or recommendation that would suggest that 3.5/2.4 is the ideal or suggested requirement. To the contrary, various reports and the federal government support staffing that caters to the specific acuity mix of the patients and facility. Facility residents should receive care based on their specific acuity. The intent of CMS regulations regarding "Sufficient Staff" under §483.35(a) is "…To assure that sufficient qualified nursing staff are available on a daily basis to meet residents' needs for nursing care in a manner and in an environment which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life." §483.60(a) regarding "Staffing," states "The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)…" Thus, a one-size-fits-all approach is impractical, and a limited scope employee such as a specified number of CNAs will not achieve the same quality outcomes for a higher acuity patient than a more highly trained employee. To ensure safe patient care and high standards, CMS guidelines state all facilities must develop a facility specific assessment that considers their patient acuity, diagnosis, etc. and staff.

The 2.4 direct care service hour formula is arbitrary and capricious and there is not qualitative data to support it – especially the minimum of 2.4 direct care service hours from CNAs. How is it in the residents' best interest to mandate more lesser trained and qualified staff to care for them? The Obama Administration and CMS in October 2016, rejected the notion of 4.1 nursing hours per patient day and shift ratios: *"We do not discount the relationship between staffing levels and quality. We disagree that this requires that we set minimum staffing ratios and that we know what that minimum staffing ratio should be. As discussed previously, we believe that there are concerns about utilizing a minimum staffing standard and we do not necessarily find that the 4.1 hours per resident day (hprd) is the right standard for every facility. LTC facilities are varied in their structure and in their resident populations. Some facilities are Medicare-only SNFs that focus on short term rehabilitation services. Others are primarily Medicaid facilities that include primarily long-stay residents. Many are both. Some facilities specialize in dementia care. Some facilities have pediatric residents, young adult residents, or ventilator dependent residents. The care needs of each of these populations are different. Facilities range in size from the very small to the very large. The capabilities of these facilities are likely to be different. As noted above, we discuss our concerns with establishing a minimum staffing ratio in prior responses. As stated in the proposed rule, our intent is to require facilities to make thoughtful, informed staffing plans and decisions that are focused on meeting resident needs, including maintaining or improving resident function and quality of life."* (Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. Centers for Medicare & Medicaid Services, HHS. Published on October 4, 2016, page 273.

CAHF appreciates the current Program Flex for the Patient Needs/Acuity Waiver and recommends a similar process going forward for the Waiver

The current CDPH Program Flex allows the facility to "tell their story" and give their narrative as to why a Patient Needs/Acuity Waiver should be granted. Consistent within SB 97, Program Flex does not automatically deny an applicant nor does it rescind a waiver once it has been granted. The Patient Needs Waiver is for facilities who do not need 2.4 CNA hours, and have evidenced as such with their patient care results and quality of care history.

CAHF believes that more qualified and specialized staff can lead to better resident care and quality outcomes. Thus, a strict mandate for less specialized direct care workers that doesn't take into account these realities is unreasonable. Therefore, facilities that meet or exceed the overall 3.5 direct care service hours requirement with licensed nursing staff, but are unable to comply with the 2.4 CNA direct care service hour requirement should not be punished for having more qualified and specialized staff on the floor. Rather, the facilities should be able to qualify for a waiver under these

circumstances. The basis of this waiver would be consistent with CMS regulations and should be in the best interest of the resident's care, the facility and the community.

Items that DPH could require from a facility when granting the Patient Needs Waiver are as follows:

- If the facility has a Subacute unit.
- If the facility has contracts or agreements with certain hospitals or health plans which prefer or encourage more licensed staff over hours from CNAs.
- If the facility serves a patient population where licensed nurses provide care normally provided by CNAs.
- Patient quality awards or recognitions the facility has recently received that demonstrates quality patient care
- Recent Quality and Accountability Supplemental Payment (QASP) awards
- CMS 5-Star rankings showing quality of care.
- Recent AHCA Gold/Silver/Bronze awards.
- Recent survey results which show quality of care and sufficient resident outcomes are being delivered at the facility.
- Positive staffing indicators such as lower turnover, continuity of administrative and nursing management, positive patient surveys etc.

We thank you for the opportunity to participate in the Stakeholder Meetings and to follow-up with additional written comments. CAHF respectfully requests that the regulations for the Patient Needs Waiver are fair, reasonable, and in the best interests of the residents and maintain access to care. If we can provide any additional information please don't hesitate to contact us.

Sincerely,

Matt Robinson, Director of Legislative Affairs