CALIFORNIA ASSOCIATION
CAHF
OF HEALTH FACILITIES

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VIA EMAIL AND U.S MAIL

RE: SB 97 Implementation; Staffing Waiver for Skilled Nursing Facilities

The California Association of Health Facilities (CAHF) was invited to participate in a provider stakeholder meeting on August 11, 2017 to discuss implementation of certain provisions of SB 97. As a follow-up to that meeting, we would like to formally submit the following general comments and concerns.

Prior to the passage of trailer bill SB 97 (2017) and its new staffing mandates for skilled nursing facilities ("SNFs"), California's SNFs were already suffering from a long-standing work force crisis involving a shortage of certified nursing assistants ("CNAs"). The new CNA 2.4 hours per patient day mandate will only serve to exacerbate this crisis. CAHF estimates it will likely require California's SNFs to employ at least 1,400 new CNAs by July 2018 and cost the state's Medi-Cal program an additional $50 million. (This does not take into account turnover or non-renewal of certification). As a result, it will be impossible for many facilities to achieve the new mandate of 3.5 nursing hours per patient day ("NHPPD") and also consistently meet 2.4 direct care service hours for CNAs. Without reasonable waiver criteria applicable to both the 3.5 and 2.4 direct care service hour requirements, these facilities will be unfairly subjected to unreasonable risks of regulatory enforcement and civil liability despite providing adequate care to residents. Therefore, it is imperative that obtainable and reasonable waiver language be adopted to exempt certain facilities.

It is unreasonable and impossible for many facilities in the state to meet the new mandates under the timeline of the new statute. As of April 2017, there were only 50 facility-based CNA training programs, 133 approved public education training programs and 212 private vocational CNA programs. Many of these programs are approved but not active. To assure that facilities can hire the necessary CNA staff to meet the new mandate, CNA training programs must be appropriately funded and have the capacity to attract enough individuals who have a particular interest in working in long term care facilities. Given the current environment and lack of existing programs, there will not be enough new CNAs in California by July 1, 2018.

A reasonable waiver process is necessary for facilities who are not able to comply with the new staffing mandate due to workforce supply issues, and there is existing precedent for needed waivers under CMS regulation §483.35(e). Without a reasonable and obtainable waiver, the only way for a provider to deal with this challenge

is to take beds out of service until they can find enough staff to fill their buildings. The result of this policy could lead to shrinking our Medi-Cal nursing home bed supply at a time we need it the most - as we face the much talked about "Silver Tsunami" of our rapidly expanding senior population.

This is a pivotal time for California to ensure that the current supply of SNFs remain economically viable so we don't prevent patient access to long term care while we work to find ways for our industry to find the additional direct care staff necessary to meet the state's new staffing requirements. California continues to see 1,100 residents turn 65 years-old every day, and our occupancy rate is at 88 percent. Approximately two-thirds of a SNF patient days are utilized by Medi-Cal beneficiaries. California SNFs are a needed safety net to provide quality long-term care and rehabilitation services for this population.

Quality of care is a top priority for CAHF members, and we are proud to say California's SNFs rank among the highest in the nation in quality. We can do better as an industry, and we are working aggressively to do so. Appropriate staffing is a big part of continuing to improve upon these quality rankings. We have never articulated that adding staff is a bad idea. We simply oppose doing so if a strict mandate ignores the facility specific nature of our current delivery of care, staffing and reimbursement. To do this right, it will take work and participation from all stakeholders and state departments.

For optimal quality outcomes, residents in facilities should be cared for based on their specific acuity. The intent of regulations from the Centers for Medicare and Medicaid Services ("CMS") 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, this enhancing their quality of life." Under §483.60(a) regarding "Staffing," the section 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 not recommended, and a limited scope employee will not achieve the same quality outcomes for a higher acuity patient than a more specialized employee. To ensure safe patient care and set standards, CMS guidelines state all facilities must develop a facility specific assessment that takes into account their patient acuity, diagnosis, etc. and staff accordingly to those needs.

Contrary to some comments by certain groups, there has never been a federally recognized or funded standard for the minimum number of nursing hours, or staffing ratios. In fact, the Obama Administration and CMS in October 2016, rejected the notion of 4.1 nursing hours per patient day and shift ratios as part of the CMS Rule of Participation Rulemaking. It stated:

"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.)

One of the Quality Measures used by CMS to determine the facilities overall Five-star rating is staffing. The measure is based on nursing home staffing levels. CMS rates facility staffing on two measures: 1) registered nurse hours per resident day and 2) total staffing hours (RN + LVN+ CNA hours) per resident day. A Five-star rating for RN staffing is displayed separately on the Nursing Home Compare website. In order to achieve an overall staffing rating of five stars, facilities must achieve a rating of five stars for both RN and total staffing.

While CAHF values the contributions of CNAs in delivering care to residents, they are not necessarily the direct care service workers that typically drive quality outcomes in SNFs. CNAs are limited in the types of services they can provide to residents (i.e. bathing, cleaning, assistance with ambulating, etc.). Licensed vocational nurses ("LVNs") can perform these same services, but also possess specialized training and a more significant scope of practice. Likewise, registered nurses can do everything and more than LVNs based upon their training and scope of practice. It is CAHF's experience that SNFs with greater numbers of licensed nurses (LVNs and/or RNs) are more likely to produce better outcomes.

CAHF believes that more qualified and specialized staff can lead to better resident care and quality outcomes. However, a strict mandate for less specialized direct care workers without taking these realities into account is unreasonable. Therefore, facilities that meet or exceed the overall NHPPD 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 and other relevant circumstances. The basis of this waiver would be consistent with CMS regulations, and in the best interest of the resident's care, the facility and the community.

Sincerely,

Matt Robinson, Director of Legislative Affairs