February 28, 2018

Scott Vivona, Assistant Deputy Director
Center for Healthcare Quality

Chelsea Driscoll, Chief
Policy and Enforcement Branch
Licensing and Certification Program

California Department of Public Health
1615 Capitol Avenue, MS 3201
Sacramento, CA 95814-5015
VIA EMAIL AND U.S MAIL

RE: SB 97 (2017) Implementation of 3.5/2.4; Workforce Shortage Waiver for Skilled Nursing Facilities

The California Association of Health Facilities (CAHF) was invited to participate in the final stakeholder meeting on February 22, 2018, primarily to discuss the third draft ("Revision 2.21.18") of the Workforce Shortage Waiver provided by the Department of Public Health (DPH), which is required by SB 97. As a follow-up to that meeting, we would like to formally submit the following comments and concerns.

CAHF RESPECTFULLY REQUESTS A DELAY AND PHASE-IN OF THE SB 97 REQUIREMENTS TO MITIGATE THE ACCESS SHORTAGE THAT WILL OTHERWISE BEGIN ON JULY 1, 2018.

For numerous reasons, CAHF's 850 skilled nursing facilities (SNFs) would like to comply with the 3.5/2.4 direct care service hours requirement in SB 97. However, within the current depleted workforce environment and proposed SB 97 timeframes and regulations, patient access will drastically decline because the SNFs are set up for failure. Without reasonable delay of the SB 97 regulations and waiver criteria applicable to both the 3.5 and 2.4 direct care service hour requirements, these facilities will be unfairly subjected to shrink bed supply and residents will be denied access to healthcare services. CAHF continues to respectfully request the delay of SB 97 implementation and a regulatory "phase-in" period to ultimately meet the 3.5/2.4 mandate.

Of the 1,039 facilities in California that will be subject to SB 97 from the most recent 2017 data, 463 facilities do not meet the 2.4 CNA requirement; 145 facilities do not meet the 3.5 nhppd requirement; and 549 facilities meet neither the 3.5 nor 2.4 requirement. Over 1,600 new full-time CNA's must appear in our workforce by July 1, 2018 to meet the new mandate (there are NOT 1,600 unemployed CNA's searching for jobs in SNFs in California, nor are there sufficient training programs and applicants in place to meet the timeline). As July 1, 2018 quickly approaches, there are hundreds of facilities that are likely non-compliant until occupancy and bed supply are reduced in order to meet the ratio (which is detrimental to access to care when California SNFs are on average 88% occupied with residents). These large numbers of non-compliant SNFs are consistent with the DHCS Medi-Cal estimate that was reflected in the Governor's 2018-19 Proposed Budget (a recognized AB 1629 basic add-on cost to meet a new state mandate). Moreover, if the counting rules for calculating the increase to 3.5/2.4 does not match the current 3.2 regulations (HSC 1276.65(a)(1) "..to the same extent as those hours are recognized by the department pursuant to Section 1276.5 on July 1, 2017") come July 1, 2018 and after final regulations are adopted, even more facilities will be non-compliant and actual Medi-Cal costs and closures will

increase while patients suffer. **These numbers are a conservative estimate based on approximately 600 Workforce Waiver Submissions between April 1, 2018 and July 1, 2018 to the DPH from facilities that are unable to comply with the SB 97 mandate.**

A phase-in of the SB 97 requirements is not unprecedented territory from DPH or the Administration. Under a far-less problematic and non-prescriptive increase in 2000 (the increase from 3.0 to 3.2 nhppd – see Department of Health Services letters from Brenda Klutz 2000, 2001), the regulations and enforcement were delayed to help assist facilities with compliance. SB 97 is a much more drastic and problematic increase. SB 97 is a significantly sharper and problematic increase (the current 3.2 nhppd to 3.5 nhppd, in addition to a prescriptive mandate of 2.4 hours being from CNAs, which are the hardest to attract/find/hire/retain as outlined below and in previous conversations. Moreover, the newly mandated 2.4 CNA minimum requirement consists of 75% of the total minimum hours for the current 3.2 nhppd).

DPH's CURRENT DRAFT WORKFORCE SHORTAGE WAIVER IS OUTSIDE THE SCOPE OF SB 97, ARBITRARY AND CAPRICIOUS, AND FURTHER LIMITS ACCESS TO CARE.

To make matters worse, the recent "Revision 2.21.18" released by DPH still contains automatic denial criteria that addresses already regulated compliance history standards – not workforce shortage needs. **Based on this draft, approximately 476 SNFs will be automatically denied a waiver** because of the Federal Deficiencies and Stat Citations enumerated as conditional elements within the waiver.

It is imperative that reasonable waiver language be adopted to exempt certain facilities. Unfortunately, DPH's second draft of the Workforce Shortage Waiver is far from reasonable or fair, and is outside the scope of the clear language in SB 97 and Health and Safety Code (HSC) 1276.65. Additionally, it is unfounded and outside the scope of SB 97 to limit the Workforce Shortage Waiver to a 2-year period or attempt to ban judicial review and appeals for applications.

DPH is clearly required to establish a waiver for facilities that serves to "address a shortage of available and appropriate health care professionals and direct caregivers." HSC 1276.65(l) states "*The department shall adopt emergency regulations or all-facility letters, or other similar instructions, to create a waiver of the direct care service hour requirements established in this section for skilled nursing facilities by July 1, 2018, to address a shortage of available and appropriate health care professionals and direct caregivers…*" DPH's recent draft does not comply with this mandate and unnecessarily limits facility access to waivers based on various "compliance" metrics that are not enumerated in the implementing statute of SB 97. DPH is required by SB 97 to address a shortage of workers - not to make it nearly impossible for facilities dealing with a shortage to obtain a waiver.

There are already numerous avenues for oversight of troubled facilities by DPH and other agencies, including methods to determine whether a facility is in "good standing." Incorporating various portions of "compliance" history into something that is focused on an environmental product such as the workforce shortage waiver is completely misguided and unjust. Similarly, it would be hypocritical to discount a facility's waiver request because of workforce shortage when those facilities experience higher than average staff turnover.

Moreover, facilities will be unnecessarily and improperly subject to regulatory enforcement and civil liability despite providing adequate care to residents (e.g. the $677 million Skilled Healthcare class action lawsuit that bankrupted one of the largest skilled nursing providers in California without one substantiated allegation of substandard care).

There is existing precedent for 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. This could lead to shrinking California's Medi-Cal nursing home bed supply at a time when it is most needed

- as we face the "Silver Tsunami" of our rapidly expanding senior population. As currently drafted, the waiver will result in longer hospital stays for residents and less time in SNFs, despite the residents' needs.

WITHOUT A DELAY AND PHASE-IN PERIOD, THE FUNDAMENTAL STATEWIDE WORKFORCE ISSUE WILL REMAIN UNADDRESSED.

California SNFs receive approximately two-thirds reimbursement from Medi-Cal and the remainder from Medicare. SNFs are almost completely reliant on funding from California and the Federal government not only to care for residents, but also to compensate employees. Because our SNFs are in one of the most regulated sectors in healthcare and business, there is no room for "cost-shifting" or "cost cutting." CAHF's members wish there was a statewide answer to solve the workforce shortage in California, but we realistically understand it will take years to formulate and implement a viable solution. (See recent supporting articles which support these points from "SEIU" and "Skilled Nursing News" respectively: http://www.seiu.org/2016/04/nursing-home-workers-to-join-fight-for-15-to-raise-wages-improve-quality-of-care; https://skillednursingnews.com/2018/01/7-caregivers-prefer-work-nursing-homes-report-finds/). It is unrealistic to hold SNFs to an increased staffing mandate and make them responsible for finding, training, hiring and retaining over 1,600 employees who do not even exist in the workforce.

While we appreciate the four stakeholder meetings convened by DPH starting in October 2017, **there has been no collaboration from other stakeholder groups to address and help solve the fundamental and underlying workforce problem.** CAHF appreciates the Governor's proposed budget, which includes Workforce Development funding that is completely outside of the SB 97 process, but in no way will this solve the major issues that will confront us on July 1, 2018.

WE APPRECIATE THE FACT THAT DPH WILL MAKE THE ACUITY WAIVER REQUIRED BY SB 97 ACCESSIBLE WITH THE DRAFT REGULATIONS SCHEDULED TO BE POSTED MARCH 30, 2018.

Contrary to the assertions of certain stakeholders, 3.5/2.4 does not guarantee quality of care. At the current 3.2 nhppd minimum standard, California currently ranks as one of the best quality outcome states in the country and continues to make improvements every year. In addition, there has never been a federal mandate or study that would suggest that 3.5/2.4 is the ideal or suggested requirement. To the contrary, reports and CMS support staffing catered to the specific acuity mix of the patients and facility. While we appreciate the large and important role of CNAs, facilities that are above the 3.5 requirement should not be excluded from the Workforce Shortage Waiver for 2.4 only because they have more qualified, specialized and higher trained staff on the floor (i.e. everything a CNA can do, an LVN or RN can do. In fact, to help address the current CNA workforce shortage problem even prior to the passage of SB 97, many facilities use LVNs in place of CNAs and the LVNs perform typical CNA functions – and we would ask for that role to be counted towards the 2.4 requirement in SB 97).

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, this 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 mandated number of CNAs to meet the 2.4 requirement 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 considers their patient acuity, diagnosis, etc. and staff.

There has never been a federally recognized or funded standard for the minimum number of nursing hours, or staffing ratios, or minimum number of CNAs. Likewise, there has never been a qualified study or adopted report that suggests 3.5/2.4 delivers better quality of care outcomes for residents than any other type of staffing mix. This has been the case prior to and after the passage of SB 97 (2017), and similar unsuccessful attempts by the proponents with SB 779 (2015 – Hall) and AB 2079 (2016 – Calderon). The Department of Finance opposed AB 2079, with contributing analysis by DPH, stating "It requires a level of staffing in freestanding skilled nursing facilities without consideration as to whether this level reflects certain patient needs and acuity in a particular facility on any given shift or day; Raising staffing requirements in accordance with this bill could lead facilities to reduce the number of available beds to comply with the increased staffing requirements…". 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 of the lesser trained and qualified staff to care for them? As stated in previous papers and meetings, 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 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 considering these realities is unreasonable. For these reasons, 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. Similarly, facilities that cannot find/attract enough employees because of numerous extrinsic factors should not be unfairly punished. They 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.

For these reasons, CAHF respectfully requests a delay in the implementation of SB 97 and a specific phase-in of the 2.4 direct care service hour requirement.

Sincerely,

Matt Robinson, Director of Legislative Affairs