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HOUSE OF REPRESENTATIVES
COMMONWEALTH *of* PENNSYLVANIA

House Democratic Policy Committee Hearing

Nursing Homes

Monday, May 13, 2024 | 1:00 p.m.

Representative Kyle Mullins

OPENING REMARKS
1:00 p.m. Rep. Kyle Mullins, D-Lackawanna

PANEL ONE
1:05 p.m. Bill Conaboy, Esq., President & CEO
Allied Services Integrated Health System

James Cooney, HSE, NHA, Vice President of Skilled Nursing Operations
Allied Services Integrated Health System

Q & A with Legislators

PANEL TWO
1:35 p.m. Noelle Lyon-Kovaleski, Administrator
Carbondale Nursing and Rehabilitation Center

Q & A with Legislators

PANEL THREE
2:00 p.m. Megan Barbour, Director of Long Term Care Transformation Office
Pennsylvania Department of Health

Jeanne Parisi, Deputy Secretary for Quality Assurance
Pennsylvania Department of Health

Q & A with Legislators

PANEL FOUR
2:35 p.m. Zach Shamberg, President & CEO
Pennsylvania Health Care Association

Written Testimony of

Carbondale Nursing and Rehabilitation Center

Delivered by

Noelle Kovaleski

Administrator

Public Hearing on Nursing Homes

Delivered before the
House Democratic Policy Committee

May 13, 2024

Members of the Democratic Policy Committee,

Thank you for the opportunity to speak at today's hearing.

My name is Noelle Kovaleski, and I am the administrator at Carbondale Nursing and Rehabilitation Center, located about 30 minutes north of Scranton in Carbondale.

I also oversee Ellen Memorial Health Care in Honesdale and Bonham Nursing and Rehabilitation Center in Stillwater. I feel as though it is important for you to be familiar with the communities we serve, as it is the members of those communities that are currently being impacted by the unintended consequences of regulations, workforce limitations and inadequate funding.

Collectively, the three centers I oversee account for 320 skilled nursing beds throughout Lackawanna, Luzerne, and Wayne Counties. Nearly 100 beds are unable to be used, primarily because Medicaid funding does allow for us to increase our workforce to meet higher staffing ratios to staff those beds.

To help tell the story of what is taking place in almost every nursing facility across the state, I want to share the experiences I am encountering as an administrator at Carbondale Nursing and Rehabilitation Center.

I recently received an email from a long-term care newsletter with the headline, "remember why you are here." It was a good opportunity to reflect on my "why".

My "why" started when I was 16 years old working in the dietary department at a local nursing home. I connected with many of the residents, but one touched my heart. Her name was Mary and she never married or had children, and no one ever came to visit with her. She was often irritable and was difficult to make happy.

I befriended Mary and would visit her on my days off, bring her favorite snacks, and listen to her stories. Mary wasn't irritable, she was quiet and intelligent and was just misunderstood by the staff. I made a positive impact on her, as she did on me. It was then I realized that I wanted to bring positive changes into the residents' lives and not just by bringing snacks and visiting. I wanted to have a bigger impact to make sure all the Mary's of the world felt loved and were well cared for.

After more than 30 years of providing care, long-term care is one thing I know best. I have seen the industry evolve in many ways, including the prioritization of paperwork over patients due to the increase in regulations that have been implemented. I have also seen a decrease in the value of care as evident by the lack of funding made possible to support the low-income residents that I serve.

We have always had to be creative and resourceful to achieve our goals. Unfortunately, being creative and resourceful is no longer a viable option.

It is abundantly clear that the long-term industry is in a crisis. COVID -19 was the breaking point for the already struggling industry and we are having a difficult time recovering given the continued regulatory demands with no money or resources to comply with them. At the same time, the demand for care only continues to rise, leaving us in a position to turn elderly patients and adults with disabilities away from receiving the care they want and need.

Staffing shortages continue to be our number one problem at Carbondale. We are struggling to fill open nursing positions and we are competing with the other health care sectors for a very limited pool of staff.

To put it into perspective, I had an Indeed ad for an 11-7 RN position running for 2 years and no applicants applied. It is dire that we retain the staff that we already have because it is difficult, if not impossible, to replace them. This also comes with its own set of challenges as you cannot effectively discipline staff for their performance because you cannot afford to lose them.

The state staffing ratios that became effective in July 2023 packed a giant punch to long-term care and to Carbondale. To attempt to comply with the ratios we have been forced to limit our census to 86% capacity. This is leaving our hospitals with less resources to discharge patients and our community with decreased availability to place their loved one close to home. Our facility is consistently at 86% capacity, and we turn away on average 20 residents a month, forcing them to drive further from their homes for a facility- if that can find a facility willing to admit them.

In theory, the staffing ratios were to have a positive impact on patient care and improve the working environment for staff. Unfortunately, the reality is they are causing stress, burnout, and increased turnover for staff. It's also forcing many facilities to use contracted workers from agencies, who offer no consistency in the care of residents. But if there is a last-minute call-out, the regulatory reality is that shifts have to be filled and administrators are required to find someone with the proper qualifications to work that shift.

The ratios do not leave us any room for error. At Carbondale, when life happens and a direct care worker must call out sick or tend to a family emergency, it is others on staff and nurse management that are asked to work past their shift to cover for others that call out. It is hard to retain or recruit staff when they are expected to choose work over family to meet staffing ratios.

I can honestly tell you that after 30 years in long-term care, a one-size-fits-all approach to providing care is not effective or efficient. Administrators like myself are licensed to know how to properly care for residents. Providers must be trusted, and regulatory flexibility granted, for any operations of caregiving across the state in nursing homes to be sustained.

I am neither proud nor embarrassed to share that Carbondale has been consistently operating in negative margins since the early days of the COVID-19 pandemic. We are not different from other providers that make up the statewide average of a -12% operating margin from 2022 data. This is the situation we are in because we care for an overwhelming majority of low-income residents from your communities. Unfortunately, the state doesn't feel it is necessary to uphold its responsibility of adequately reimbursing providers through Medicaid for the costs we incur to ensure quality care is provided and state mandates are met.

The increase in Medicaid funding for the staffing mandate in the 2022-23 state budget was helpful, but it doesn't come close to covering our costs. The nearly 10 years of flat funding prior to the increase did not allow us to keep up with the pace of rapidly increasing costs. The average increase in our nursing wages alone since 2020 has been $4.00 to $7.00 more per hour depending on the position, and we are still having to provide more incentives to stay competitive.

The population we are caring for is sicker, more complex, and therefore more costly. Our Medicaid reimbursement for Carbondale, the money that is supposed to be repaid to us for the costs to care for low-income residents, fell short of the average cost to care for a patient each day by $39.62 in 2023. Nearly 75 percent of our residents rely on Medicaid to pay for their care. This equated to a reimbursement shortfall of $1,020,000. That's more than $1 million that could help us recruit and retain staff with higher wages, and new ways to further enhance resident care.

What many don't see is that the expenses are not just housing and staffing costs. On any given day we are caring for an average of 18 residents that are Medicaid-pending- meaning, that state should be paying for their care, but the state has yet to approve payments. Essentially, we are providing free care by covering all costs with no reimbursement in sight.

Carbondale alone consistently has between $500,000-700,000 that we are waiting to get payment on for residents that are still pending Medicaid approval. Given the complexity of the application it can take 9 months to well over a year for final approval. During the waiting period the facility provides care, food, shelter, activities, transportation, medications with no return payment. We are literally living payment by payment to pay our bills as we have no money in reserve. You can't find any other landlord that operates like this. But we have no choice. We are talking about the lives of a vulnerable population in need of care. They can't be evicted out into the streets.

This isn't even getting into other areas where residents and families refuse to pay their patient portion of the costs, which is the amount Medicaid determines they need to contribute to the cost of care.

I could give many more examples of the limitations we have but in the interest of time, these are just a few of the variables that make it impossible to survive any longer in this industry. The reimbursement is not adequate, and the pipeline of staff is not out there to comply with the mandates. We are barely making enough to pay our bills and we have zero money to invest

back in our physical plant to make improvements. We are forced to do without so that we can attempt to continue to pay our staff, pay our vendors and provide for the residents the best we can.

This is why I say I am neither embarrassed nor proud of our financial situation. We have nothing to be embarrassed about at Carbondale because we are doing everything we can to sustain quality care, invest in our workers and pay our debts. At the same time, we are not proud of the situation we have been put in. We are not proud to know that the care of our residents, your constituents, is undervalued. We are not proud of operating in fear that our operations cannot be sustained; leaving residents like Mary, the reason I entered this career, from not receiving the care they need.

Is this what we really want for our rapidly aging population? Do we want to bring this essential component of the health care continuum to its knees because of unattainable mandates and a lack of investment in care? Do we want to risk mass closures that back up the hospital systems and leave our elderly with nowhere to go for care? Because that is starting to happen and will only continue to get worse if action is not taken.

It is obvious that we need a plan to help introduce more caregivers into long-term care. We need realistic staffing regulations and more funding to be able to make improvements and recruit more employees. We need help now before it's too late!

I'm aware that many buildings are up for sale in mass proportions because they are on the brink of closure. I know that banks are limiting funding to long-term care due to the high risk of bankruptcy, and insurance companies are denying us due to the risk of liability.

There is no looming crisis. We are in the crisis now, and we need to stop it from spreading to further devastation. You can help address this crisis and we can help work with you to do that.

We want to provide great care, have staff who want to come to work and to invest back into our facilities. We want our residents to be happy and our families to feel at ease leaving their loved ones in our care. I want to fulfill the dream I had as a 16-year-old of making a positive impact on residents. I will continue to fight for my residents until changes are made or I am no longer able to fight. I will continue to speak out on their behalf to all that will listen.

We need a solid and consistent investment in long-term care so that we can continue to give our aging population the care that they earned and deserve.

Thank you for your time and attention to this matter.

Noelle Kovaleski, NHA
Carbondale Nursing and Rehabilitation Center

Megan Barbour, MPH

Director of the Long-Term Care Transformation Office

Pennsylvania Department of Health

Testimony to the

Pennsylvania House Democratic Policy Committee

Monday, May 13, 2024, | 1:00 p.m.

Introduction

Members of the House Democratic Policy Committee, thank you for this opportunity to come before you to discuss the current state of skilled nursing facilities (SNFs) in our Commonwealth and the Department of Health's actions to support them across our communities.

Pennsylvania has the third-highest percentage of people over 60 in the U.S., and the fifth-largest population of older Americans. As of 2022, more than 20% of Pennsylvanians are age 60 or older. As our population ages, the demand for quality long-term care options will continue to grow. Currently, long-term care facilities (LTCFs) are struggling from multiple standpoints including recovering from COVID-19, maintaining fiscal sustainability, and recruiting and retaining a workforce. These challenges stem from a lack of resources and support for these facilities. Without such support, quality care can suffer and result in even more challenges for residents and staff. Furthermore, the workforce crisis specifically in our long-term care communities is a systemic issue. For too long, staff and administrators have received limited resources while operating in an increasingly complex environment. While being under-resourced and experiencing workforce issues are just a few of the challenges they face, previous attempts to solve these dilemmas have only made incremental progress. One of the Shapiro Administration's responses to these challenges is the establishment of the Long-Term Care Transformation Office housed in the Department of Health to help build sustainable resiliency in long-term care facilities.

Our Office

The Long-Term Care Transformation Office was established in January 2023 to address the fractures, inequities, and vulnerabilities of our long-term care system exposed during the COVID-19 pandemic. Currently federally funded, the Office predominately operates two programs—the Long-Term Care Resiliency Infrastructure Supports & Empowerment (LTC RISE) Initiative, and the LTC Quality Investment Pilot (QIP) Program—which are designed to create resiliency in LTCFs, including SNFs, personal care homes, assisted living residences, and

intermediate care facilities. Additionally, the Office uses its non-regulatory role in the Department of Health to:

- Coordinate with the internal offices of our department and our sibling agencies, including the Department of Human Services and the Department of Aging, to establish informed programming that promotes best practices in LTCFs;

- Build and facilitate relationships between facilities and regional partners, including emergency preparedness organizations and other stakeholders;

- Liaise with state and national stakeholders to learn about best practices and receive feedback on our state's efforts to support SNFs; and

- Research and identify metrics to be used in building alternative payment models in LTCFs and support bidirectional information sharing with stakeholders during this research.

LTC RISE

The purpose of LTC RISE is to provide LTCFs with quality improvement activities that contribute to long-term success, and ultimately better care for residents. This program is voluntary, allowing facilities to enroll only if they choose. The Office partners with four regional grantees to implement six types of activities that include leadership improvement, frontline staff assessment and skill building, infection prevention and control, immunizations, emergency preparedness, and resident care. The four regional grantees include Lake Erie College of Osteopathic Medicine (LECOM) Health, AMI Expeditionary Healthcare, Penn State Health, and Penn Medicine in partnership with Temple Health.

Currently, over 80% of all SNFs within Pennsylvania have voluntarily enrolled in LTC RISE and have worked with our regional partners to strengthen their facilities by participating in quality improvement activities.

QIP Program

While LTC RISE provides SNFs support through regional partners, QIP offers SNFs the chance to invest in themselves. In 2024, this program provided $14.2 million to more than 120 facilities for the purpose of investing in workforce development within their communities and making infrastructure improvements. SNFs, alongside personal care homes, assisted living residences, and intermediate care facilities were able to choose from several tracks centered around resiliency as shown below.

The QIP Program has been hailed as a remarkable example of government supporting facilities because we prioritized collaboration and understanding of their needs and directly provided them the funds needed to succeed. This program has allowed the Long-Term Care Transformation Office to gain a better understanding of the needs of Pennsylvania's facilities and will allow us to

move forward more informed than ever to continue our support with the goal of enhancing care for residents.

We hope this is just the beginning of enduring and much needed support our department will be able to provide.

Collaborating with the General Assembly

The Department of Health and Long-Term Care Transformation Office has identified several immediate opportunities to engage and collaborate with the General Assembly in supporting SNFs.

Currently, the Long-Term Care Transformation Office and its programs are federally funded, with funding set to expire on July 31, 2024. Governor Shapiro has proposed $10 million to codify state funding for our Office in the 2024-2025 Budget to continue to directly support SNFs, and we hope the General Assembly will support this budget request. This is the first time in Pennsylvania's history that an Office has ever been established with the sole purpose of working with stakeholders to understand industry challenges and implement positive change. Without permanent state funding, the support outlined today will be severely limited in a time where more and more homes are seeking any form of assistance.

Moreover, our Office vocally supports the implementation of quality-based payments to LTCFs. As we develop future renditions of QIP and LTC RISE, we are ever mindful of the impact quality-driven programs have proven to make. The Shapiro Administration understands this as well and that is why the Department of Health began engaging with The National Academy for State Health Policy (NASHP) State Nursing Home Policy Academy. In engaging with 8 other states across our country, Pennsylvania is learning more about what it takes to implement a full-scale, quality-based payment program for SNFs. The Department stands ready and willing to work with its sister agencies and the General Assembly on quality-based payment programs in Pennsylvania, as these methods may reduce overall expenditures and can lead to an increase of quality of services for residents.

Finally, a common misconception is that our Commonwealth has a formal Certified Nurse Aide program that acts as a career ladder to further job opportunities. However, such a program has yet to be established in regulation or law, and only the position of Nurse Aide has been established. This position derives from federal law and regulation and is an integral part of the long-term care workforce. In Pennsylvania, this program is overseen by three separate agencies: the Department of Education, the Department of Human Services, and the Department of Health. Within the Department of Health, our department is responsible for registration of nurse aides in SNFs, while the Department of Education oversees the education of nurse aides, and the Department of Human Services oversees the testing examination. Prospective employees are required to undergo over 100 hours of training before applying for its examination, but less and less training centers are becoming available across our counties. By supporting access to training centers and access to exam sites, we can increase the workforce pipeline and ensure all our SNFs are properly staffed. Similarly, as noted above, the Department would be a willing partner in

discussions with other agencies and the General Assembly that would consider additional ways to bolster the healthcare workforce pipeline in long-term care.

Conclusion

The Shapiro Administration, the Department of Health, and the Long-Term Care Transformation Office believe that everyone should be able to age with dignity. No matter where a person receives their care, whether it is at home, at a personal care home, an assisted living residence, or a SNF, everyone deserves access to affordable, quality care. The challenges facing Pennsylvania are not unique, but we hope that our continued collaboration can ensure we face these hurdles head on. Thank you for the opportunity to be here today, and I look forward to answering any questions that you may have.

Regional Map

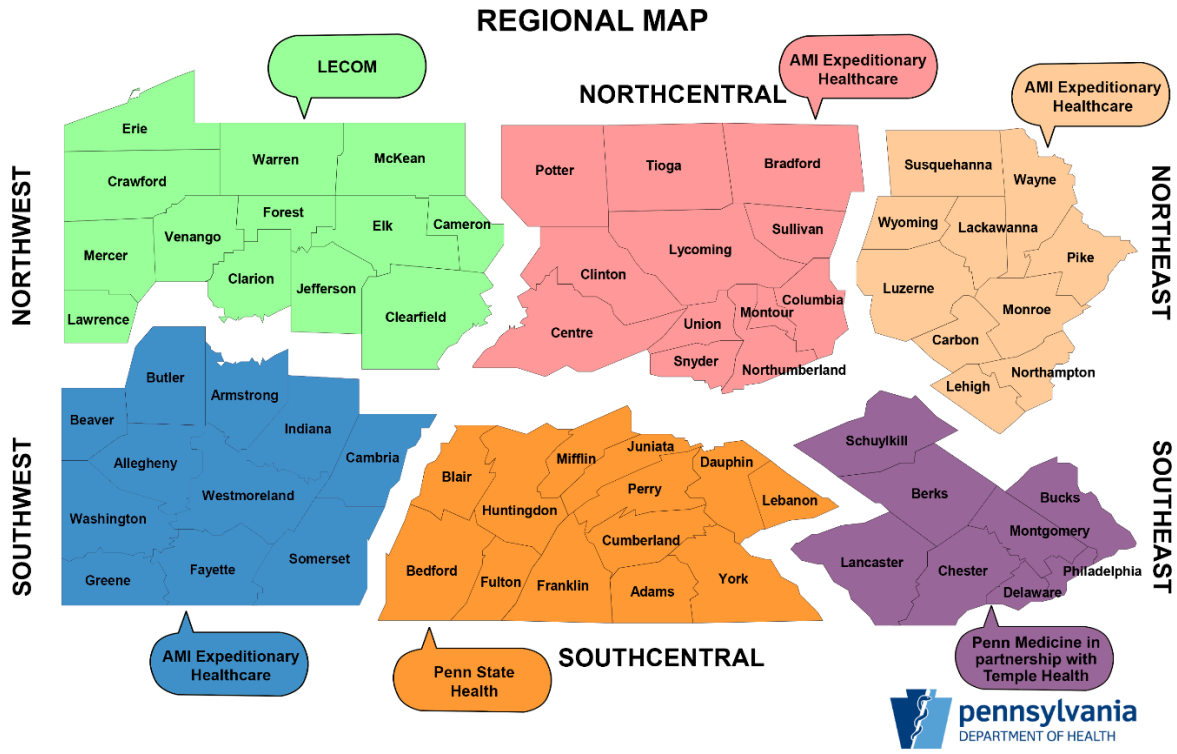


Table 1

Table 1. Tracks 1-4: Workforce Interventions to Improve Retention and Build Resiliency			
Track 1. Leadership/Management Development	Track 2. Clinical Skills Training	Track 3. Infection Prevention and Control	Track 4. Emergency Preparedness
Track 1 is designed to build skills among facility managers and directors in several areas including hiring and workforce retention, occupational health, navigating change in facility culture consistent with other areas in this pilot, governing regulations, legal and other critical areas.	*Track 2 is for existing licensed health professionals (RN, LPN, pharmacist) and for CNAs to expand their clinical skills so more staff within facilities are able to provide daily healthcare services.*	*Track 3 expands a facility's knowledge and ability to identify and respond to infectious disease threats, improve understanding of disease transmission and control, and implement a rapid outbreak response strategy.*	*Track 4 is intended for facilities to gain ability to develop and maintain an all-hazards emergency operations plan, engage with external partners (regional hospitals, emergency management, police, fire/EMS agencies, public health), participate in drills and exercises and respond to emergencies affecting residents and staff.*
1.A: Identify managers for training in key business enhancing areas (all facility types and sizes available for this option). Maximum 2 people per facility.	**2.A: Identify existing staff for clinical skill certification training** (all facility types and sizes available for this option). Maximum 6 people per facility.	**3.A: Identify an Infection Prevention Champion** (all facility types and sizes available for this option). Facilities may identify an existing employee with potential to understand infectious disease transmission and outbreak response actions. Employee will need to complete certification designated by the Department. Maximum 2 people per facility.	**4.A: Identify an Emergency Preparedness Champion** (all facility types and sizes available for this option). Facilities may identify an existing employee with potential to understand and respond to all hazard emergencies for the facility. Employee will need to complete certification designated by the Department. Maximum 2 people per facility.
1.A: Estimated Costs ($28,000 per person)	**2.A: Estimated Costs ($32,000 per person)**	**3.A: Estimated Costs ($30,500 per person)**	**4.A: Estimated Costs ($27,000 per person)**
Certification Tuition: $20,000 per person	Certification Tuition: $20,000 per person	Certification Tuition: $20,000 per person	Certification Tuition: $20,000 per person
50% staff time to complete certification: $3,000 per person	50% staff time to complete certification: $2,000 per person	50% staff time to complete certification: $3,000 per person	50% staff time to complete certification: $2,000 per person
Salary Increase: $5,000/year after certification/training completion per person for one year	Salary Increase: $10,000/year after certification/training completion per person for one year	Salary Increase: $7,500/year after certification/training completion per person for one year	Salary Increase: $5,000/year after certification/training completion per person for one year
Tracks 3 and 4 have an additional option to hire a full time Infection Preventionist or an Emergency Preparedness Coordinator. These options (3.B, and 4.B below) are restricted to facilities with 120 or more licensed beds.			

Table 2

Table 2. Tracks 5-7: Infrastructure Interventions to Improve Infection Prevention Control and Emergency Preparedness

Track 5. Technology and Communications	Track 6. Ventilation and Airflow	Track 7. Biocontainment and Control
Track 5 options allow facilities to invest in technical equipment and upgrades to introduce and expand systems to improve resident care and communications between staff, residents, family members and healthcare providers.	*Track 6 options allow for improvements in air handling and flow to improve air filtration and circulation to reduce airborne health hazards.*	*Track 7 allows facilities to expand and improve spaces (resident rooms, common areas, hallways) to better separate infectious and exposed residents to contain transmission, plus improve access to hand hygiene stations for staff*
5.A: Telehealth kiosks (including telehealth carts, tablets, laptops, computers, monitors, and headphones)	**6.A: Purchase HEPA filter**	**7.A: Install handwashing stations** in hallways and other areas easily accessible for staff caring for residents **Quote required*
5.A: Maximum amount: $25,000	6.A: Maximum amount: $3,000	7.A: Maximum amount: $50,000
5.B: Improve internet access or Wi-Fi connectivity to enhance communications during emergency, or enable telehealth	**6.B: Upgrade HVAC system** ***this intervention requires applying for 6.D: Airflow Analysis*	**7.B: Install hand sanitizer stations** that are easily accessible to staff and visitors and purchase supplies.
5.B: Maximum amount: $2,000	6.B: Maximum amount: $10,000	7.B: Maximum amount: $7,500
5.C: Cellphones or walkie talkies to allow for emergency communication. Funds may be used to purchase devices.	**6.C: Improve circulation and airflow opportunities** in critical areas to improve ventilation **Quote required, **this intervention requires applying for 6.D: Airflow Analysis*	**7.C: Divide non-single occupancy rooms** to improve infection control. Funds may be used to put up safe and effective barriers within multi-resident rooms. Barriers must be in accordance with all fire safety requirements. **Quote required*
5.C: Maximum amount: $3,000	6.C: Maximum amount: $30,000	7.C: Maximum amount: $50,000
5.D: Call bell system installation or upgrades	**6.D: Airflow analyses** to support decision-making about ventilation improvements	**7.D: Create or improve biocontainment units** (red zones) to enable better isolation of sick patients. Funds may be used to put in barriers and exists and entrances in spaces identified by the facility to serve as biocontainment areas for infected residents. **Quote required*
5.D: Maximum amount: $2,000	6.D: Maximum amount: $500	7.D: Maximum amount: $75,000
5.E: Software to allow for virtual provider or family visits, for example, secure provider patient portal		**7.E: Upgrade visitation spaces** to improve infection control. Funds may be used to add barriers to create separate spaces towards building entrances to limit public movement in facilities. **Quote required*
5.E: Maximum amount: $3,000		7.E: Maximum amount: $50,000

House Democratic Policy Committee

May 13, 2024

Testimony of

Jeanne Parisi, MPA

Deputy Secretary for Quality Assurance

Members of the House Democratic Policy Committee, thank you for extending the invitation to speak about the state of skilled nursing facilities (SNFs) in Pennsylvania. The Department of Health shares the committee's concern about the complex regulatory and economic environment long-term care facilities navigate while providing essential services to Pennsylvania's older adults and residents with disabilities.

In my role as Deputy Secretary of Quality Assurance within the Department of Health, I oversee the Bureau of Long-Term Care Programs, which includes regulatory enforcement over SNFs. Prior to coming to the Department of Health in March 2023, I acted as the Director of the Bureau of Human Services Licensing at the Department of Human Services. Within both roles, I have witnessed the shift occurring in facilities serving older adults towards for-profit and private-equity ownership. It has been estimated that nationwide, nearly 70 percent of long-term care nursing facilities are owned by for-profit entities. This trend has been particularly noticeable to the Department over the past two decades.

Private equity (PE) firms have recently become interested in owning SNFs. PE firms are known for conducting leveraged buyouts, in which an entity is purchased by borrowing the cash needed to make the purchase. The PE firms that buy SNFs rarely have direct experience in caring for older adults. In a working paper published by the National Bureau of Economic Research concerning private equity acquisition of nursing facilities, Gupta et al. found that PE firm purchases of nursing homes are generally associated with higher patient mortality, insufficient staffing, higher management fees, and a decline in patient mobility. PE firms often seek to aggressively return revenue to investors, which may be different from other for-profit SNF owners, who usually prioritize stable profits. Because most PE funds have a set time-horizon to return cash to their investors, assets tend to be held for shorter periods of time. There is little incentive to maintain the business as-is, prompting short-term efforts to relieve the facility's high debt burden, which can lead to instability in facility operations eventually resulting in facility closures and increasing issues with access to care.

The Department is greatly concerned about the lack of transparency involved with PE restructuring of SNFs into complicated financial assets. In an effort to limit financial liability and seek profit, PE firms will usually split individual facilities into real-estate holdings (which are sold to another entity) and operation companies. The new owner of the real-estate may charge the operation company rent. In some instances, the real-estate will be sold to an entity owned by the same PE firm. This lack of cash on hand creates considerable hardship for the SNFs, which

can directly impact resident care. Gupta et al. in their survey of SNFs witnessed lower Registered Nurse (RN) coverage in PE owned facilities. Complex ownership structures generally make it difficult for residents and their families to determine exactly who owns the facility, who owns the real-estate property that the facility occupies, and most importantly, who exactly is responsible for the care of residents in the facility.

Given that 75% of SNF revenue nationwide is received from Medicare and Medicaid programs, the Department supports increased oversight over the financial and ownership operations of all SNFs, including ones owned by PE interests, for the best use of taxpayer dollars. The Biden administration recently formalized new regulations which will require SNF operators to report overall amounts spent on patient care. This is a valuable first step in addressing this issue. The Department welcomes the partnership of the legislature in determining additional appropriate methods for safeguarding patients' safety in all SNFs. It is paramount to consider that the Department will need increased staffing and resources for any proposed reform endeavors.

The Department is aware that the Centers for Medicaid and Medicare Services recently published a final rule which will provide residents in SNFs with a minimum total of 3.48 hours of nursing care a day. The Bureau of Long-Term Care Programs is currently investigating how these regulations will impact our ongoing state regulation implementation. Last year the Department of Health revised its long-term care nursing facility regulations to update the minimum health and safety standards for Pennsylvania SNF residents. Several new requirements for licensure were established, including all applicants for licensure providing notice to the LTC Ombudsman; all applicants for licensure from a change in ownership providing notice to facility staff and residents; and requirements for audited annual financial reports as a condition for license renewal. Notice provisions related to changes of ownership went into effect on February 1, 2023. Most other licensure requirements went into effect July 1, 2023, including the first step in the gradated staffing minimum increase to 2.87 nursing service hours per day. On July 1, 2024, the minimum staffing requirements of 3.2 nursing service hours will go into effect.

Surveys completed since July 1, when the new regulations were implemented, consistently identify approximately 80% of SNFs are in compliance with the new staffing requirements. National research supports that increased staffing results in better quality of care and we frequently see that lack of compliance with the new staffing requirements correlates to increased non-compliance in other areas, as well as complaints and incidents.

The Department is aware that facilities in rural areas may be facing more challenges with filling positions, and that some SNFs are maintaining a lower census to meet the new staffing requirements. Our focus remains on the increased quality of care assured to residents by adequate staffing and support all workforce development initiatives to increase healthcare staffing throughout the industry.

The frequency and complexity of complaints has continued to increase over the past several years. The Department now receives an average of approximately 500 complaints per month, and to investigate these complaints in a timely manner, the Department has spent $1.4 million in the last fiscal year in overtime. Pennsylvania is one of the few states without a backlog in conducting

surveys but does not have the staff required to reduce the dependence on overtime or monitor at-risk facilities more frequently. Additionally, while the Department is now collecting financial information from facilities prior to approving new ownership and at renewals, the only recourse available to us when we identify facilities at-risk financially is to increase our monitoring. To ensure the Department is focused on the safety of residents as prescribed in our Long-Term Care Regulations, the Governor has requested 18 new positions in his proposed budget for this year. These positions, if funded, it would allow the Department to reduce our dependence on overtime and increase monitoring in both routine surveys and complaint surveys as well as ensuring compliance with newer regulatory oversight provided by the recent updates to our Long-Term Care Regulations. We look forward to partnering with the General Assembly on that funding request as we move forward into June.

Thank you again for the opportunity to be with you today. I am happy to take any questions you may have at this time.

Written Testimony of

PHCA
PENNSYLVANIA HEALTH CARE ASSOCIATION

Delivered by

Zach Shamberg

President and CEO

Public Hearing on Nursing Homes

Delivered before the
House Democratic Policy Committee

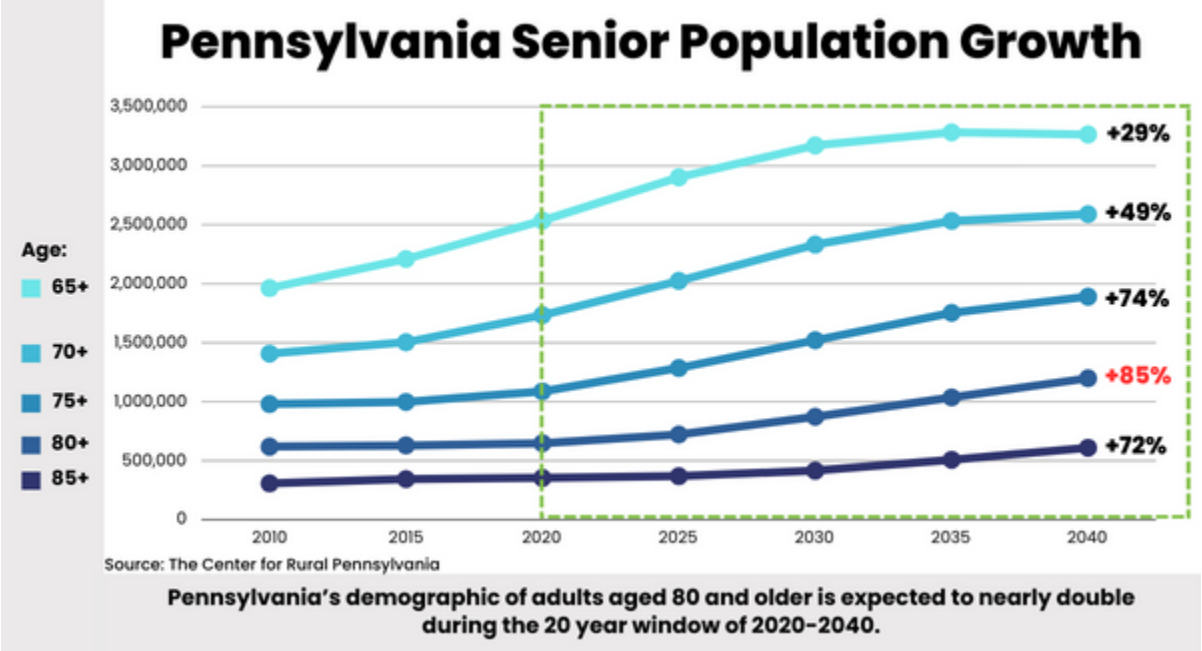
May 13, 2024

Chairman Bizzarro and members of the House Democratic Policy Committee: thank you for the opportunity to testify today and offer input from the older adults services community.

My name is Zach Shamberg, and I am the president and CEO of the Pennsylvania Health Care Association, or PHCA. We are proud to represent long-term care across the commonwealth, including government-run, nonprofit and for-profit nursing homes, as well as personal care homes and assisted living communities. The residents our members serve are Pennsylvania seniors in need of care, or adults with mental or physical disabilities.

Serving Pennsylvania's seniors and adults with disabilities is the mission of long-term care providers. And right now, that mission means working through a crisis in which access to care has become an issue due to limited resources.

I want to first set the stage for my testimony by sharing with you some details about Pennsylvania's demographics. By 2030, Pennsylvania will have more adults aged 65 and older than young adults and children aged 19 and younger. Our fastest growing demographic today is adults aged 80 and older. That particular age group will nearly double by 2040 from what it was in 2020, pushing that demographic to 1.2 million people in 16 years.



Pennsylvania's demographic of adults aged 80 and older is expected to nearly double during the 20 year window of 2020-2040.

Why are we so focused on this age group? Because it is commonly around this age that seniors enter a long-term care community for care. At the same time, people are living longer, and we are seeing a growing demand for care earlier in their senior years – especially a need for dementia care.

I'd also like to note that with an increasing aging population, more of your constituents will be relying on the state's Medicaid program to pay for their care.

By now, you've probably heard of the "silver tsunami". Well, that wave of seniors is here, and we fear Pennsylvania is not ready to weather the storm that is set to come crashing down.

Unfortunately, long-term care is commonly an afterthought, or an option that many believe they will never need. We don't want to think about our later years in life when our health and daily capabilities diminish, requiring others to provide for us. Thankfully, we represent providers that want to provide care and have positioned themselves to be there for us. Unfortunately, however, long-term care providers across the state are facing immense challenges — and our nursing home providers, more specifically, are struggling to keep their doors open.

Within the past five years, more than 20 nursing facilities across the state have closed. Dozens of others have sold to new ownership. This is not a good sign or trend. In a survey we just conducted of our membership, nearly 50 percent of the owners that completed the survey said they have plans to sell or close their Pennsylvania facilities within the next year because of viability concerns. To give you an idea of what that would mean: six percent of all nursing facilities (or approximately 5,200 nursing facility beds) would be gone *if* just these survey respondents closed their doors. I don't need to tell you how alarming this is if you take our small survey sample and apply it to all facilities across the commonwealth.

So what's the primary issue? With a majority of Pennsylvania seniors relying on Medicaid to cover their cost of care — which is about 70 percent of all care in nursing homes — providers simply can't pay their bills. Your response to that might be, "that's because of corporate greed." No. It's not, because you need to have profits to have greed. The average profit margin from 2022, the most recent data available, was -12 percent for nursing homes in our state.

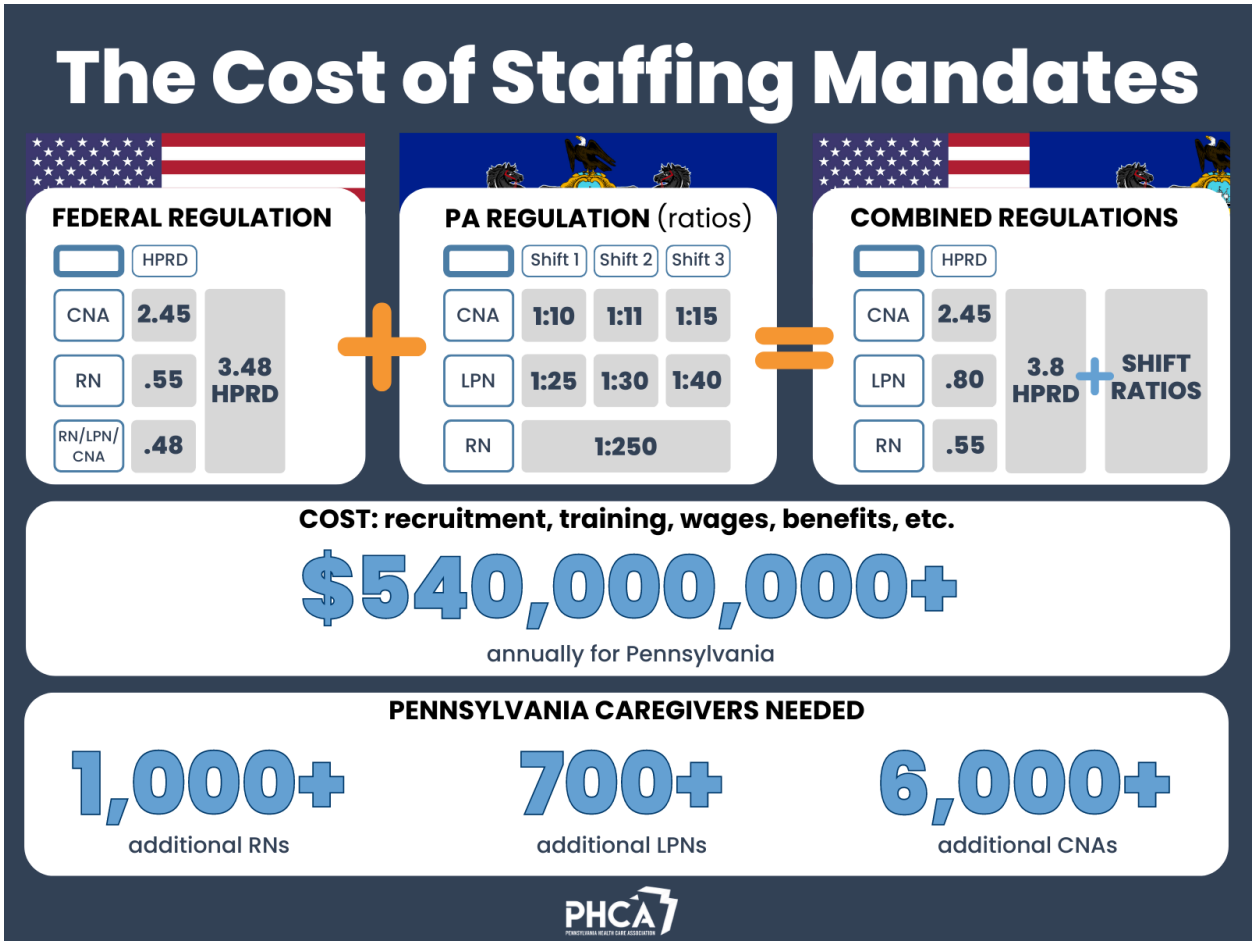
Let me say that again: -12% margins. Name another business or industry on earth that could survive at that rate.

How did we get here? For too long, Pennsylvania simply did not invest in senior care. And when we finally did, the investment was to partially support a new, increased staffing regulation that was finalized in 2022. Two years ago, we were proud to work with then-Governor Tom Wolf, members of the General Assembly, SEIU Healthcare and other stakeholders to identify a way to enhance resident care and fund it. Unfortunately, the continuation of that funding fell short last year, so now providers are left attempting to meet another unfunded mandate – while also trying to offset the funding shortfall that already existed.

That Medicaid funding shortfall, on average, is now more than $40 per resident per day. If you run the numbers for the amount of Medicaid recipients in nursing homes in this state, that shortfall equates to more than $650 million per year.

Making this critical component of the healthcare continuum even less viable will be the federal staffing mandate the Biden administration just finalized and tacked onto the Pennsylvania mandate. Even if these mandates were funded, there still are not enough workers to meet them

— not without discharging residents and denying care. Combined, Pennsylvania providers will need 8,000 more qualified caregivers and nearly $540 million just to meet these two mandates.



Now add in the Medicaid reimbursement shortfall ($640 million). And in a few weeks, when Medicaid rates are rebased with new cost reports that are continuing to incorporate more COVID-19 costs from the height of the pandemic, prepare to tack on at least another $500 million.

This isn't a question of profits. Remember: there are no profits. The real question is: how much does Pennsylvania value its most vulnerable and venerable population?

When you compare the cost of care provided in a nursing home vs. the stay in a hospital without surgery, lab tests, or doctors fees, you can truly see the disparity in Medicaid reimbursement rates. As you will see in this analysis conducted by the Independent Fiscal Office (IFO) in October on Pennsylvania's Strained Nursing Homes, it costs roughly ten times more to keep a patient in a hospital than to discharge to a long-term care facility.

Some might say the solution is keeping more people at home for their care. We do not disagree that home care is a critical component of the healthcare continuum, but it isn't the right solution

for everyone. The homeless rate among seniors is on the rise. Acuity levels, dementias, and behavioral health needs are all on the rise. The cost to keep seniors in their home is on the rise and has now, on average, surpassed the annual cost of nursing care when comparing per beneficiary costs. Above all, home care is far less regulated than nursing care — there is limited oversight of the care that is being provided in a home, leaving our vulnerable loved ones and neighbors even *more* vulnerable.

The other key issue is that with any part of the healthcare continuum, there are simply not enough caregivers or an existing pipeline of caregivers waiting to enter the careers we have available.

I mentioned the staffing mandates earlier – we came to the table during those discussions and shared our concerns about the timing of the mandates. We aren't against enhancing care. Every provider in this state wants to hire more direct care workers. There is just not enough funding to even try to recruit and hire more caregivers because the mandates have not been fully funded.

Providers want to pay their staff more to retain them and recruit more qualified caregivers. In the four years between 2019 and 2023, the average statewide wage for certified nurse aides (CNAs) increased by 26 percent to nearly $20 per hour. I'd also note that of the funding that providers do receive, 70 percent of all costs must be resident care costs — these costs are primarily staffing costs. This is another provision we championed to make sure funding was going to the care of the residents and those providing the care — ensuring real accountability.

But the workers aren't available, so providers are forced to hire costly contract staffing agencies to help fill shifts. Providers can't even afford these agencies, yet they have to bring staff in to meet the regulations. This is not ideal, because providers are being price gouged and the continuity of care is disrupted.

Two years ago, PHCA worked closely with members of the General Assembly to enact Act 128, legislation that provides minimal guardrails around these staffing agencies. Though portions of Act 128 have been implemented, we are anxiously awaiting the promulgation of regulations, as required under this Act, to place additional stipulations on these organizations. The Department of Health has until the end of November to promulgate the regulations, and to date, stakeholders have not yet been contacted to offer feedback. Just as we, the provider community, have to meet regulatory deadlines, we hope the Department will meet their obligations on time as well.

We've now outlined the challenges, but that doesn't mean that PHCA and our members are not working toward solutions.

First, new and more funding is essential to the sustainability of long-term care. We are actively requesting a Medicaid rate increase in the 2024-25 state budget to help offset the original cost of the state staffing mandate.

Additionally, PHCA is proud to propose a new way to allocate supplemental funding to providers that is directly tied to quality metrics, holding providers even more accountable.

It's budget season, and you will see plenty of groups and constituencies holding their hands out throughout the next few weeks. But we guarantee those groups aren't simultaneously asking for more accountability of those dollars like we are. PHCA has designed a quality incentive program called **ecwip**, or Enhancing Care With Incentivized Payments. **ecwip** holds providers accountable for the quality of care delivered to the residents in their care – the better the resident outcomes, the higher the reward payment. For underperforming providers, **ecwip** limits or withholds any additional funding to drive enhancements in resident care. This payment model drives investment to providers who are laser-focused on high-quality resident outcomes and weeds out those that are not. The target metrics will be measured quarterly with payments following suit to get more dollars into the hands or providers quicker so they can maintain the enhancements they have made.

PHCA is requesting for this model to be adopted and funded with $100 million annually.

We are also championing legislative initiatives to help expand careers in long-term care and break down career-entry barriers. There is a package of workforce bills in the state Senate that also have companion bills in the House that we encourage you to support.

These bills are:

- Senate Bill 1102
    - works to modernize Certified Nurse Aide (CNA) training in Pennsylvania by establishing a uniformed, state-wide CNA training program, allowing nurse graduates and students to take the CNA certification exam without completing the nurse aide training program.
- Senate Bill 1103
    - allows for interested caregivers to take a skills competency examination if they cannot produce a high school diploma or GED.
- Senate Bill 1104
    - allows high school juniors and seniors to obtain credit towards graduation requirements for working in congregate care settings.

Additionally, Senate Bill 668 is bipartisan legislation that passed the House Health Committee in March and is awaiting second consideration. We encourage the House to consider this important workforce initiative without delay, and we ask members of this Committee for your support. This bill establishes a new position in nursing facilities: the certified medication aide (CMA). This position not only expands the workforce career ladder, but it will also help offset the shortage of licensed practical nurses (LPN) and registered nurses (RN) who are currently the only licensed individuals permitted to disperse medications. SB 668 includes a robust training program and would allow CMAs to handle low acuity medication delivery while LPNs and RNs focus on more complex patients.

Lastly, I'd encourage you to support Senate Bill 520, legislation that will allow for assisted living communities to become Medicaid-eligible. Pennsylvania is one of only a handful of states that does not allow for assisted living to be Medicaid-eligible. We have an access to care crisis, and it's evident that the Baby Boomers have not saved enough and seniors cannot afford to privately pay for care. But we also know that not every senior needs skilled nursing care. By making assisted living Medicaid-eligible, seniors will have more options to receive care while maintaining their independence in a senior living community. This new option will also save the state money by having less residents admitted to the more costly nursing home option.

As advocates for the vulnerable residents of our state, we cannot sit by and watch the care infrastructure for our fastest growing demographic come crashing down. Collectively, we all need to take action today to get ahead of the wave that is beginning to tower over us.

We are committed to supporting the care of Pennsylvania seniors and adults with disabilities, but we need you and our state to commit to supporting long-term care.

Thank you for the opportunity to testify, and we look forward to working with you in the weeks and months to come.