Assembly
California Legislature

ASSEMBLY COMMITTEE ON HEALTH
JIM WOOD, CHAIR
ASSEMBLYMEMBER, SECOND DISTRICT

Informational Hearing

Skilled Nursing Facilities in California: Licensing, inspections and quality of care issues.

Tuesday, October 5, 2021 – 1:30 to 4:30 p.m.
State Capitol, Room 4202
BACKGROUND

INTRODUCTION

California's over-6o population is projected to diversify and grow faster than any other age group. By 2030, 10.8 million Californians will be an older adult, making up one-quarter of the state's population.

According to the Skilled Nursing Facility (SNF) dashboard on the California Department of Public Health (DPH) website, as of September 21, 2021, there have been a total of 54,005 confirmed COVID-19 cases in SNF health care workers (HCWs), and 63,564 cases among SNF residents. There have been 249 HCW deaths, and 9,213 SNF resident deaths. The total number of COVID-19 cases in California across all age groups has reached 4,448, 666, with 68,087 fatalities.

In June 2020, the Assembly Health Committee held an informational hearing titled: "The Covid-19 outbreak in Skilled Nursing Facilities and the State's Response: A discussion of what has worked, what has not, and what are plans for the future?" The hearing provided an overview of the state's response to the "severe acute respiratory syndrome coronavirus 2" (COVID-19) outbreak in SNFs, primarily, the effect the disease had on residents and their families. At the hearing, patient advocates, state regulators, and industry members provided testimony and engaged in a roundtable discussion on how to enhance and improve the COVID-19 response in SNFs. In the 2021-22 Legislative session, numerous bills were introduced to address the issue of the severe COVID-19 outbreak in SNFs, as well as to address long-standing issues related to the state's licensing and inspection process for SNFs.

While COVID-19 deaths in SNFs had decreased over the last several months due to the widespread vaccination of SNF residents, there has recently been another surge due to the Delta variant. As the pandemic continues, it is important to understand and acknowledge the significant impact the over 9,000 deaths of individuals residing in SNFs had on their friends and families.

This hearing will be more broadly focused on the current SNF licensing and inspection process, including an update on changes made by DPH since the most recent State Auditor Report. The hearing will also explore concerns related to SNF licensing and inspections and the quality of care provided to SNF residents, and examine the ownership structure of SNFs and potential impacts on quality of care. The Committee will also hear recommendations from various stakeholders to improve the quality of care provided in SNFs.

BACKGROUND

SNFs. In California 1,215 SNFs provide care to 96,296 residents and patients. SNFs are licensed and regulated by DPH and provide skilled nursing and supportive care to patients whose primary need is for the availability of skilled nursing care on an extended basis. These include free-standing nursing homes and 'distinct part' nursing homes which are attached to hospitals. In 2020, the reported average cost per patient day for a SNF was approximately $304 ($110,960 annually). Medicare and private pay costs are usually higher. SNF occupancy rates in California are approximately 87%. According to the Office of Statewide Health Planning and Development (OSHPD) 88% of facilities are proprietary (i.e., run by for-profit corporations (26%), limited liability companies (51%), health care districts, counties, or other public agencies) and 12% are nonprofit.

DPH is responsible for ensuring SNFs comply with state laws and regulations. DPH Licensing & Certification (L&C) staff conducts on-site inspections of long-term care (LTC) facilities (including SNFs) and responds to approximately 6,650 complaints and 19,300 events reported by facilities each year. Events that facilities are required to report to DPH (reportable events) include interruptions of services essential to the health and safety of residents; alleged or suspected abuse; all fires, disasters, and other risks to resident life or health resulting from accidents or incidents at the facility; and, administrator or director of nursing personnel changes. Investigation of complaints and reportable events also require on-site inspections. These inspections, called surveys (also conducted by DPH L&C staff), evaluate compliance with both state and federal requirements.

DPH's Center for Health Care Quality (CHCQ), L&C Program. L&C is responsible for administering the licensure, regulation, inspection, and certification of health care facilities (including SNFs) and certain health care professionals in California. L&C is organized into 14 district offices and Los Angeles County, which operates under a contract with the program. L&C staff conduct periodic inspections and investigation of complaints and entity-reported incidents to ensure health care facilities comply with state and federal laws and regulations, conducting more than 30,000 complaint and entity-reported incident investigations of LTC facilities annually. L&C also contracts with the federal Centers for Medicare and Medicaid Services (CMS), which provides federal funding, to ensure that facilities accepting Medicare and Medi-Cal payments comply with federal laws and regulatory requirements. In addition to facility oversight, L&C oversees the certification of certified nurse assistants (CNAs), home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

L&C requires LTC facilities to correct less serious deficiencies by implementing a written plan of correction without incurring fines or other penalties. If warranted, L&C may impose a fine, appoint a temporary manager or receiver, suspend or revoke the facility's license, or use other remedies for violations as provided by state or federal law. While L&C can impose state fines, it can only recommend to CMS that a federal remedy other than a written plan of correction be imposed. CMS may impose, modify, or waive DPH's recommended remedy.

History of Problems with Health Facility Oversight. L&C's regulatory oversight of health care facilities has been fraught with allegations of inefficiency compromising patient safety. Concerns have been raised by the federal government, the Legislature, the California State Auditor (CSA), stakeholders, and the media for more than ten years. In particular, L&C has demonstrated a consistently poor record of completing investigations of health care facility complaints of abuse and neglect of residents in a timely manner.

The concerns date back prior to 2006, when SB 162 (Ortiz) Chapter 241, Statutes of 2006, established DPH as a separate department from the Department of Health Services (DHS, now the Department of Health Care Services (DHCS)) effective in July of 2007. When SB 162 was heard in the Assembly Health Committee, the analysis noted the following:

"There has been longstanding perceived ineffectiveness within the L&C Section of DHS in all areas of responsibility, such as licensing; inspections; and investigations of family, consumer, and anonymous complaints, all of which endanger patient safety, prevent providers from obtaining licenses and renewals in appropriate time frames, and create significant inequities in the fees supporting these activities."

***CSA (2007)* -** The L&C program was the subject of a 2007 state audit that found investigations were promptly initiated for only 51% of its 15,275 complaints and promptly completed only 39% of the time. The audit noted that, despite efforts to increase staffing, the reliance on nurses to conduct complaint investigations resulted in struggles to fill vacant facility evaluation staff positions due to low salaries and a shortage of available nurses.

***Federal Office of Inspector General (2011, 2012, 2014)* –** The L&C program was the subject of three separate reports from the federal Office of Inspector General for the U.S. Department of Health and Human Services. These reports found that L&C was not meeting its federal oversight requirements for health care facilities pursuant to Medicare and Medicaid laws and regulations. In particular, L&C investigators were not properly identifying unmet federal requirements in its surveys and inspections of health care facilities.

***CSA (2014)* –** The L&C program was the subject of a second audit in 2014 that found systemic problems associated with completing timely health care facility complaint investigations that were substantially similar to the problems identified by the Auditor in 2007. The new audit found that, as of April 2014, the L&C program had more than 10,000 open complaints and entity-reported incidents against long-term care facilities and nearly 1,000 open complaints against

individuals. Many of these complaints, including those indicating a safety risk to one or more facility residents, had remained open for nearly a year.

Los Angeles County Investigation, Audit (2014) – In 2014, an investigative report published in the *Los Angeles Daily News* discovered the Los Angeles County Department of Public Health was administratively closing health care facility complaints of abuse and neglect that were submitted anonymously without completing an investigation. In response, the county's Board of Supervisors ordered an audit of the county department's Health Facilities Inspection Division (HFID). This review found more than 30% of complaint investigations had been open for more than two years, there was no central state or county monitoring of complaint investigation completion or timeliness, and HFID could neither identify the number of staff devoted to investigations nor the number of staff it would need to complete investigations timely.

Hubbert Systems Consulting Assessment and Gap Analysis (2014) – In response to concerns expressed by the Legislature, L&C contracted with Hubbert Systems Consulting to perform an organizational assessment and evaluate areas where L&C was experiencing challenges and barriers contributing to less than optimal performance. Hubbert released its report in 2014 identifying issues with completing state and federal survey and licensing workload, facility and professional complaint investigations, oversight of the Los Angeles County contract, staff vacancy and retention, and other organizational management challenges. The report also provided 21 separate recommendations for remediating these issues including improvements in leadership, performance data monitoring, workforce development and retention, and operational management.

CSA (2018) – CSA's audit: "Absent Effective State Oversight, Substandard Quality of Care Has Continued," found that the state has not adequately addressed ongoing deficiencies related to the quality of care that nursing facilities provide. One of the recommendations of the audit is for DPH to amend its application licensing reviews by developing a defined process that specifies how an analyst will determine whether an applicant has demonstrated its ability to comply with state and federal requirements. The audit notes that the process should ensure that analysts conduct complete and standardized reviews of each nursing facility application, and should clearly outline what factors analysts will consider when determining whether an applicant is in compliance. The audit also recommended, among other things, that DPH should document the additional factors higher-level management will consider if applications are elevated for their review, and to ensure that DPH documents its decisions adequately.

LICENSING

DPH Centralized Applications Branch (CAB). As noted on DPH's L&C web page, its top priority is to protect patient safety and ensure quality care for all patients and residents of the more than 11,000 health care facilities they regulate in California. In an effort to streamline and improve the licensing process, in July 2016, DPH began centralizing all application processing at its headquarters in Sacramento. The CAB processes applications in the order in which they are received, and processing times vary widely due to the complexity of the application.

According to DPH, licensees and owners are vetted by completing a compliance history that includes a list of all facilities they currently operate and all of their reported deficiencies and violations. Based on the level of severity and scope of federal and state level citations, DPH will either issue or deny the application. According to DPH, the CAB provides standardization and consistency of state licensing and federal certification through the application process. CAB consists of four sections: (1) CAB Administration Section; (2) LTC Section; (3) Non-LTC Section; and, (4) HHA/Hospice Section. The branch has 93 full time employees and three student assistants.

CAB processes initial applications for providers seeking to open a new facility, Change of Ownership (CHOW) applications for existing licensed facilities that are being sold, thereby changing the licensee, and employer identification number, and all other Report of Changes (ROC) required to be reported to DPH. DPH has received 16 Initial (new SNF license) applications since 2015. Of those applications, one was denied, three were withdrawn, one was deemed incomplete, and 11 applications were approved.

In calendar year 2020, CAB received over 9,000 Initial, CHOWs, and ROC applications, across all types of facilities. CAB has experienced an increase in workload each year since 2017. The volume of applications and processing timeframes vary by facility and application type. To view application volume and processing timeliness, visit the CAB Processing Metrics Dashboard located at https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/CAB.aspx

The current volume of incoming applications from 1/1/2021 – 4/30/2021

Application Type	Initial New licensure	CHOW	ROC	Total
Volume	**1,290**	**110**	**2,739**	**4,139**

The chart below represents the number of initial (new) SNF applications received broken out by year and average processing time.

Year	Count of Initial Applications	Average of Open Days from Received to Complete
2015	5	416.4
2016	1	322
2017	3	521.67
2018	4	535
2020	3	68.33
Grand Total/Average	**16**	**372.68**

CHOWs. DPH states that a SNF CHOW application takes, from start to finish, on average, 492 days. This includes the paper application process, a survey by the district office, and any additional documentation requested by DPH staff.

The number of SNF CHOWs received and the average processing time in days are in the table below.

Receive Date	Number of SNF CHOW	Processing Days in Average
2015	82	207.1
2016	82	338.9
2017	46	535.4
2018	38	448.6
2019	68	225.2
2020	35	140.2
Total/Average	**351**	**315.9**

Process for reviewing SNF compliance history for approval or denial. The CAB LTC Section has created a SNF internal checklist, which includes conducting several database checks as well as conducting a three year compliance history on any individual with 5% or more ownership interest to ensure applicants meet state licensure and federal certification requirements. After compiling the compliance report, the analyst creates a summary document, adding total of citations and deficiencies incurred by applicants in all health care facilities owned in California. The data is aggregated by year and level of deficiency and citation. The data summary is put in a table which highlights scope and severity of deficiencies incurred by applicants. The analyst summarizes the compliance history report and flags pattern and widespread deficiencies along with any A and AA citations, further discussed below. This Compliance History Grid is used to guide the process of elevating the review of the compliance history through the chain of command. All reviewers follow the standardized process as documented on the Compliance History Grid. DPH states that it has developed a process and each decision taken on a SNF application is documented adequately with its supporting materials, documents and maintained in the application file.

According to DPH, there are currently 50 SNF CHOW applications in "pending" status, and nine denied applications currently under appeal.

Management operating transfer agreements. A CHOW application may contain a management operating transfer agreement (MOTA) between the current licensee and the prospective licensee that allows the prospective licensee to operate the facility while the application is on file and pending a determination. The facility remains licensed under the current licensee. Current law is silent on the length of time in which an "interim" owner or management company may operate a facility under a MOTA, which leaves many facilities in limbo, being operated under the former owner's license. There are currently CHOW applications on file that were received in March 2016 that still are pending a determination five years later.

Pending CHOW regulations at DPH. DPH issued an All Facilities Letter (AFL) in October of 2018, notifying stakeholders that DPH is developing regulations governing the CHOW process. The AFL asked for input on the following questions:

1) What types of health facilities should be included in the CHOW regulations?

2) What type of transactions constitute a CHOW? What percentage of ownership change should be considered a CHOW?

3) What background information should DPH review to establish a "reputable and responsible character"? What person(s) should the DPH examine, that are associated with an applicant that is a firm, association, organization, partnership, business trust, corporation, or company?

4) Should DPH examine an applicant's compliance practicing under a professional license, if applicable, during the health facility application review? If so, what compliance factors are most relevant to owning a health facility?

5) In evaluating an applicant's compliance, what period of time should DPH review and consider?

6) What factors in an applicant's compliance history establish the ability or inability to follow the rules and regulations applicable to operating a health facility?

7) What criteria should DPH apply to a compliance history to determine approval/denial of a CHOW?

8) How can an applicant best demonstrate the financial ability to operate a health facility?

9) In the event of a CHOW denial, what would be the responsibility of the original licensee to take back operations of the facility?

10) Should a CHOW application be reviewed and approved by DPH before a purchase of the assets takes effect?

In 2019 DPH stated that these proposed regulations were in final development and on schedule for completion by 2022, however, in an update provided in August 2021, DPH notes that amended regulations, (Change of Ownership, (DPH 14-008) affecting not only SNF CHOWs but also those for general acute care hospitals, acute psychiatric hospitals (APHs), special hospitals, and intermediate care facilities are still in process. DPH states that the proposed regulations incorporate comments received in two stakeholder engagement meetings. The regulatory package addresses what transactions constitute a CHOW, reporting CHOWs to DPH, and the process for approving CHOWs. DPH notes that, barring unforeseen adverse circumstances, these regulations may be promulgated in fiscal year 2022-23 or 2023-2024.

SNF SURVEYS

Current survey process. Under state law, SNFs are only surveyed annually if they have had one or more citations in the past 12 months. Otherwise, the state survey interval is every two years. However, as part of the COVID Declaration of Emergency (Executive Order N-27-20) and CMS guidance, many surveys were paused to focus on COVID-19 mitigation efforts. The data below includes DPH's CHCQ licensing and certification survey activities for FYs 2017-18, 2018-19, 2019-20, and 2020-21, and shows the impact of the COVID-19 operational changes on CHCQ's survey levels.

The federal survey interval for SNFs is a 12-month *average*, but no later than 15.9 months after the last day of the prior standard survey. Special focus facilities (SNFs that have a history of serious quality issues or are included in a special program to stimulate improvements in their quality of care) may be visited more often than once a year.

DPH states that CHCQ resumed combined recertification and relicensing surveys for SNFs as of April 1, 2021, and is working to bring all facilities back into the 12-month average/15.9 month cycle.

The chart below represents surveys completed over the last four fiscal years:

Survey Type	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
***Licensing* Survey: Initial**	9	4	7	8
***Licensing* Survey: Re-licensure**	276	437	234	10
***Certification* Survey: Initial**	6	4	6	4
***Certification* Survey: Re-Certification**	1,166	1,196	859	159
Follow-Ups & Revisits	1,296	1400	1,073	356
Annual Totals	**2,753**	**3041**	**1,073**	**537**

According to DPH, in addition to the periodic surveys identified above, CHCQ has focused substantial resources during the COVID pandemic on federal infection control (FIC) surveys and state mitigation surveys. CMS required FIC surveys to focus on preventing the transmission of COVID-19. DPH performed FIC surveys as required by CMS. Additionally DPH visited SNFs at least every six to eight weeks to conduct state mitigation plan surveys validating SNF's mitigation plans. Mitigation plans were prepared in conformance with AFL 20-52 (issued May 11, 2020) and included information on Covid testing and co-horting, infection prevention and control, personal protective equipment, staffing shortages, designation of space, and communication.

The chart below represents the Mitigation (infection control (IC) State Surveys) and FIC Surveys.

SNF Survey Type	FY 2019-20	FY 2020-21	Totals
COVID/IC State Survey	833	5,271	6,104
COVID/FIC Survey	2,357	4,741	7,098

Proposed Quality and Safety Model. In 2020 DPH proposed changes to the SNF inspection/survey process in an undated memo, which stated, in part:

"Quality and Safety (Q&S) surveyors, formerly known as licensing and certification surveyors (L&C) will provide increased monitoring, timely feedback by way of statements of deficiencies when appropriate, and consistent accountability to promote sustainable regulatory compliance and improved quality of care. In addition to the once annual CMS re-certification survey, surveyors will be assigned to visit each SNF approximately once every four to six weeks, using state inspection authority to enter a facility and initiate a periodic inspection. The reason for changing the name of the surveys is to focus the survey model on the purpose of our oversight rather than on the tasks associated with DPH oversight. The Q&S Health Facilities Evaluator Nurses will identify one or more focus areas from state regulations to review/investigate during each onsite visit. Facility past compliance will be considered in the decision of which areas to be reviewed at each visit. Routine Quality and Safety Oversight periodic inspections are not intended to replace CMS recertification surveys, other CMS directed investigations or State re-licensing surveys. If, at any time during the periodic inspection the surveyor identifies potential violations of federal regulation, the surveyor shall begin an abbreviated federal investigation under existing dual (state and federal) enforcement processes as appropriate."

Advocates, including the California Advocates for Nursing Home Reform expressed serious concerns with the proposal noting that the plan would divert the surveyor workforce from investigating complaints and other problems; that legislatively mandated re-licensing surveys were not currently being conducted; and, that DPH did not consult with the Legislature or the public about the plan.

According to DPH, they have postponed efforts to revamp the SNF inspection process or move to the Quality and Safety Model as discussed in the proposal, and that this effort will be revisited once we are past the pandemic response and will include stakeholder input.

CITATIONS

DPH Citations. Current law allows for "prompt and effective civil sanctions" against SNFs and other types of LTC facilities for specific types of violations. State law categorizes citations that impose a civil monetary penalty as Class B, A, or AA. The associated fines range from $100 to $1,000 for Class B; $5,000 to $20,000 for Class A; and, $25,000 to $100,000 for Class AA. The citation class and amount of the fine depends upon the significance and severity of the

substantiated violation. Federal enforcement remedies include a written plan of correction, directed training, state monitoring, denial of payment for new admissions, ban on admissions, and fines ranging from $50 to $10,000 per day for survey violations and $1,000 to $10,000 for specific instance violations, such as a determination of immediate jeopardy or significant harm to the patient.

DPH issues AA level citations, when it determines that a facility's violation was a direct proximate cause of death of a patient or resident. The state may issue A or B level citations to LTC facilities or providers for lesser violations.

As of June 1, 2021, between January 1, 2015 and January 31, 2020, DPH issued 3,360 penalties overall where a Citation Class Code of AA, A, or B was reported. As of June 10, 2021, between January 1, 2015 and January 31, 2020, DPH cited 264,335 deficiencies/violations statewide. (NOTE: This includes deficiencies with open survey status.)

Table 1: Penalties Issued Statewide-By Penalty Type and Calendar Year
Based on penalties (1) issued between 1/1/2015 and 12/31/2020 and (2) where citation class code is AA, A, or B.

Penalty Type	Calendar Year of Penalty Issue Date						
	2015	2016	2017	2018	2019	2020	Total
1_Citation AA (HSC 1424)	9	16	15	22	12	7	**81**
2_Citation A (HSC 1424)	121	181	210	209	141	100	**962**
2_Citation B (HSC 1424)	262	443	397	442	497	276	**2,317**
Total	**392**	**640**	**622**	**673**	**650**	**383**	**3,360**

NOTE: Includes citations with open and pending dispositions.

No SNFs have lost their CMS certification during this past year, however, 12 SNFs closed in 2020, and three SNFs closed in 2021.

The 2018 audit pointed out that between 2006 and 2015, the number of federal deficiencies that DPH identified at LTCs increased by more than 30%. However, during the same time period, the number of state citations (B, A, and AA citations) decreased by 34%. According to the audit, DPH stated that the burden of proof required for state citations is higher than for federal deficiencies. The audit also recommended increasing the amount of state penalties by the amount of inflation. If the Legislature revised existing penalty amounts for inflation, a $100,000 fine, the maximum state penalty amount for a violation resulting in patient death, would increase to $146,000.

OTHER FACTORS AFFECTING QUALITY OF CARE

Related Parties. A Kaiser Health News analysis of federal inspection and quality records reveals that SNFs that outsource to related parties tend to have significant shortcomings: they have fewer nurses and aides per patient, they have higher rates of patient injuries and unsafe practices, and

they are the subject of complaints almost twice as often as independently operated homes. Related parties may provide goods such as medical supplies and equipment, laundry and linens, and food to the SNF. Related parties may also provide therapy services, maintenance services, financial consulting, and administrative services, and SNFs frequently lease their buildings from related-party property owners. These related party transactions are common in the industry, and are legally allowable, although CMS and Medi-Cal take measures to limit the possibility that it might pay for profits from related party transactions. For example, the cost for such transactions are not allowed to exceed the price of comparable transactions procured elsewhere.

The 2018 State Auditor report looked at three of the largest private operators of SNFs in California: Brius, Plum, and Longwood and their use of related parties. While the net income of the rest of the industry in California decreased, the net income of these three companies increased by tens of millions of dollars. The State Auditor found that the owners of these three companies were able to earn income, separate from the revenue their facilities earned from Medicare, Medi-Cal, or managed care, when their facilities obtained goods and services from related parties, or other businesses that they or their family members owned or controlled. According to the State Auditor, the three companies paid between $37.2 million and $65.7 million to related parties from 2007 through 2015; however, the report also found that the companies properly disclosed most of the potential related-party transactions, and that the Medi-Cal audit process ensured that Medi-Cal did not pay for profits realized from any of these transactions.

According to an analysis of nursing home financial records by Kaiser Health News, nearly three-quarters of nursing homes in the United States (more than 11,000) have such business dealings.

SNF staffing requirements. Current SNF regulations require nursing service personnel to be employed and on duty in at least the number and with the qualifications determined by DPH to provide the necessary nursing services for patients admitted for care. The staffing requirements are minimum standards only. SNFs are required to employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant state and federal staffing requirements.

Facilities licensed for 59 or fewer beds are required to have at least one registered nurse (RN) or licensed vocational nurse (LVN), awake and on duty, in the facility at all times, day and night. Facilities licensed for 60 to 99 beds are required to have at least one RN or LVN, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing services. The director of nursing services is not allowed to have charge nurse responsibilities.

Facilities licensed for 100 or more beds are required to have at least one RN, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing services. The director of nursing services must not have charge nurse responsibilities.

SNFs have frequently pointed to staffing shortages as a top operational challenge, even in the years leading up to the COVID-19 pandemic. A study published in March 2021 in the journal

Health Affairs examined pre-pandemic payroll-based journal data to assess turnover at U.S. SNFs. Using data from more than 15,000 facilities from 2017 to 2018, researchers found that the mean rates were greater than 100% across all three primary employee types studied: RNs (140.7%), CNAs (129.1%), and licensed practical nurses (114.1%).

SB 97 (Committee on Budget), Chapter 52, Statutes of 2017, required SNFs to provide at least 3.5 hours per day of nursing care to each patient, up from the previous requirement of 3.2 hours, with 2.4 of the hours to be provided by a CNA. In July of 2018, DPH adopted regulations to implement the staffing requirement, which include a process to apply for a waiver.

As of July 20, 2021, 143 SNFs have waivers of the staffing requirements approved by DPH. Waiver requests generally cite a workforce shortage of CNAs as the reason behind the request. According to DPH, the information below (last updated August 13, 2021) represents a preliminary list of county shortage areas for purposes of meeting the SNF 3.5 direct care service hours and the 2.4 CNA component requirements.

The lists are based on data from OSHPD, the Employment Development Department, and DPH. This designation is one of many criterion that DPH will consider in reviewing workforce shortage waiver applications. If a facility is in one of the counties listed, DPH will not automatically grant a facility's request for a waiver to the 3.5 or 2.4 requirements. If a facility is not in one of the counties listed, DPH will not automatically deny a facility's request.

2.4 Preliminary Counties		3.5 Preliminary Shortage Counties	
Alpine	Modoc	Alpine	Mendocino
Amador	Mono	Amador	Modoc
Calaveras	Monterey	Calaveras	Mono
Colusa	Napa	Colusa	Monterey
Del Norte	Nevada	Del Norte	Nevada
Glenn	Placer	Glenn	Plumas
Humboldt	Plumas	Humboldt	Santa Cruz
Imperial	San Francisco	Inyo	Sierra
Inyo	Santa Cruz	Kern	Siskiyou
Kern	Shasta	Lake	Sutter
Kings	Sierra	Lassen	Tehama
Lake	Siskiyou	Madera	Trinity
Lassen	Sutter	Marin	Tuolumne
Madera	Tehama	Mariposa	Yolo
Marin	Trinity		
Mariposa	Tuolumne		
Mendocino	Yolo		

CNAs. Under the supervision of RNs and LVNs, CNAs perform basic duties such as feeding, bathing, and dressing SNF patients and taking and monitoring vital signs (such as patients' temperature and blood pressure). To become a CNA, individuals must be at least 16 years old, pass a physical (health) screening and criminal background check, complete an approved training

program consisting of at least 60 classroom hours and 100 hours of clinical practice at a SNF, and pass a state CNA certification examination.

According to the most recent data (2019 OSHPD LTC Financial Pivot data set for licensed SNFs) the average wage was $16.76 per hour for CNAs, and the average number of CNAs employed in 2019 was 56,170. According to the California Association of Health Facilities, they recently conducted a workforce survey with 88% of facilities reporting they raised base wages in 2020 due to COVID-19.

According to DPH's website, California has 640 CNA training programs. (DPH counts each cohort of students being trained by a given provider as a separate program, such that a provider can be associated with multiple programs.) Training providers include school district-run adult schools and Regional Occupational Centers and Programs, California Community Colleges, nonprofits (such as the American Red Cross), and for-profit schools (such as Coast Health Career College in Orange County). They also include some SNFs that provide their own training programs on site. Under the SNF training model, SNFs hire their own instructors (often employees of the SNF) and often pay students hourly wages while they receive training. In exchange, SNFs typically ask, but do not require, students to commit to working at the SNF for a specified amount of time (such as one year) after becoming a CNA.

CNA Testing. In August 2021 the American Red Cross Association notified DPH that the Red Cross plans to discontinue performing CNA testing nationwide as of October 31, 2021. The Red Cross is one of two vendors approved to provide CNA testing in California, and conducts roughly one-third of all CNA testing in the state each year. DPH staff have been reaching out to several other CNA testing vendors (which operate in other states) as well as the other approved vendor, the California Community Colleges Chancellor's Office, to determine availability in providing additional testing to meet statewide needs. Staff are also collaborating with other state departments to strategize short- and long-term solutions for expanding the CNA workforce and making testing more accessible.

SNF funding and quality assurance fees (QAF). AB 1629 (Frommer), Chapter 875, Statutes of 2004, enacted the Medi-Cal Long Term Care Reimbursement Act of 2004, which established a reimbursement system that bases Medi-Cal reimbursements to SNFs on the actual cost of care. According to the Senate Budget Committee, prior to AB 1629, SNFs were paid a flat rate per Medi-Cal resident. AB 1629 allowed the state to leverage new federal Medicaid dollars by imposing a QAF on SNFs. This federal funding is used to increase SNF reimbursement rates. (Federal Medicaid law allows states to impose such fees on certain health-care service providers and in turn repay the providers through increased reimbursements.) Because the costs of Medicaid reimbursements to health care providers are split between states and the federal government, this arrangement provides a method by which states can leverage additional federal funds for the support of their Medicaid programs and offset state costs.

The 2018 Audit notes that the state uses the QAF (quality assurance fee) to obtain federal matching funds, not to incentivize quality improvements, and recommends that the Legislature

should amend the law to require DHCS to use QAF funds to improve quality of care in SNFs rather than returning these fees to the SNFs without condition.

SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, established the Quality and Accountability Supplemental Payment (QASP) program. Under the QASP program, SNFs that meet minimum staffing standards can earn incentive payouts from a pool of supplemental funds. The payouts are awarded based on SNFs' performance on certain quality measures (including clinical indicators), as well as SNFs' improvement on these measures relative to the previous year. As noted above, many SNFs have received waivers for staffing requirements.

CONCLUSION

The 2021-2022 State Budget, enacted on June 30, 2021, includes investments to address aging and improve the lives and well-being of older adults, families, and caregivers. Budget investments for affordable housing and access to health care have aging layered in, and there are several new aging and disability-focused initiatives: including a Home and Community Based Services Spending Plan. While those are important and necessary changes, there will always be a need for SNFs in California.

The COVID-19 pandemic disproportionately harmed older and other at-risk adults and illustrates the urgency of issues associated with DPH oversight of SNFs to ensure quality of care concerns are addressed and enforcement is done in a timely manner. Older adults have experienced unprecedented death rates, particularly among Latino, Black, and Asian Pacific Islander communities. Seniors and other individuals with chronic conditions and acute health issues need SNFs to provide the around-the-clock care they require. It is incumbent on the state to improve both the oversight of SNFs and the quality of care they provide to many of the state's most vulnerable citizens.