

# **AB 1629 WORKGROUP SUMMARY REPORT**

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LifeCourse Strategies



Funded by the California HealthCare Foundation

March 2009

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# **AB 1629 Workgroup Summary Report**

## **EXECUTIVE SUMMARY**

*The AB 1629 workgroup, representing diverse stakeholders, has the responsibility of developing AB 1629/ratesetting methodology recommendations for the Department of Health Care Services (DHCS), pursuant to W&I Code Section 14126.02(a), and may take into consideration all factors deemed relevant to ensure the quality of resident care.*

***[AB 1629 Workgroup Purpose, 11/19/2008]***

California changed its nursing home Medicaid reimbursement methodology following passage of the Medi-Cal Long Term Care Reimbursement Act of 2004 (AB 1629). The impetus behind AB 1629 was a desire by multiple stakeholder groups, and the State, to address a confluence of issues and factors challenging the viability of the skilled nursing facility industry. Chief among these issues were: the need to establish and promote a financially stable skilled nursing facility industry; and, the need to address ongoing challenges with low staffing and retention levels, high staff turnover, and facility complaints and deficiencies. During the two-year period prior to AB 1629, the skilled nursing facility industry had experienced several significant financial challenges: escalating operating costs for new staffing requirements; higher workers' compensation insurance and liability insurance costs; and, the challenge of a Medi-Cal rate reimbursement freeze.

Several other factors contributed to the development of AB 1629. Prior to the legislation, California's General Fund showed evidence that it could not support the level of additional funding required to provide a rate increase for California's skilled nursing facilities. The provider community, supported by a coalition of organized labor and specific groups of consumer advocates, offered a proposal to the State to require skilled nursing facilities to pay a Quality Assurance Fee (QAF); the QAF collected could be used by California to leverage additional federal Medicaid funding to provide the needed rate increase. Additionally, many stakeholder groups had long recognized that the Medi-Cal rate methodology, which had been in place for decades, no longer supported the level of quality of care required to meet regulatory requirements and the increasing care needs of residents. Because of this, the coalition proposed a new Medi-Cal cost-based facility-specific free-standing skilled nursing facility reimbursement system that could support and promote improved quality of care. The new rate system intended to improve staffing conditions (wages, working conditions, etc.) and facility complaints and deficiencies, by replacing the flat rate system with a facility-specific cost-based methodology with increased rates based on expenditures in five primary cost centers (see Appendix A: AB 1629 Background). The final legislation was crafted to address the following goals for the skilled nursing facility industry: to provide reimbursement to skilled nursing facilities that support quality improvement efforts; to establish a reimbursement methodology that encourages and rewards skilled nursing facilities to invest more in direct care labor; to impose a quality assurance fee to enhance federal financial participation; and to encourage capital investment.

Comprehensively evaluating outcomes of the new rate system, however, has been challenged by the bill's sunset provision, the significant lag time between facility spending and cost reimbursement, and the timely availability of facility and cost report data. To continue efforts to

both evaluate and enhance the legislation, the Health Trailer Bill of 2008 (AB 1183), contained several provisions related to AB 1629, including the establishment of a stakeholder workgroup, of interested stakeholders, to make recommendations to the California Department of Health Care Services to ensure compliance with the intent of AB 1629, as detailed in the legislation (subdivision (a) of Section 14126.02). The workgroup, comprised of 18 members representing consumers/advocates, skilled nursing facility labor, and skilled nursing facilities, together with representatives from the state departments of Health Care Services, Public Health, the Office of Statewide Health Planning and Development, and the Office of the State Long-Term Care Ombudsman, met seven times from November 2008 through January 2009. The responsibility of the workgroup was to provide AB 1629/ratesetting methodology recommendations to the Department of Health Care Services, responsible, in turn, for submitting the workgroup recommendations to the Legislature by March 1, 2009. Note: the following summary report is intended to be a reflection of the workgroup process, discussion content, and outcomes; it is not the statutorily mandated Department of Health Care Services' AB 1629 Recommendations report to the Legislature.

The abbreviated time frame for the AB 1629 workgroup and the predefined goal of developing AB 1629/ratesetting recommendations set the stage for members to participate in a dedicated process of exploring and discussing different perspectives and experiences regarding the legislation. While stakeholder differences required the group to dedicate much of their attention to establishing a fair and open process with adequate structure for discussing and vetting information, rich content discussion equally characterized the meetings. During the first few meetings, members defined the workgroup's purpose, primary goal, supporting objectives, and a decision making structure for resolving differences. Subsequently, members identified the information they needed to make recommendations and then discussed factors associated with ensuring the quality of resident care. Among the many issues discussed by workgroup members, several emerged repeatedly, inspiring engaged discussion and debate albeit no specific resolution or final determination. These included the definition and measures of quality, pay-for-performance, and data collection and reporting.

Workgroup member(s) submitted four sets of recommendations organized into two groups: the first identified issue areas with multiple recommendations; and the second organized non-overlapping recommendations into four broad content categories. Both groups of recommendations included group and individual votes, supporting information from submitting organization(s), and submitted written comments (note: the public was invited to submit recommendations outside the workgroup process to be included in the final summary report). Because of time constraints, members were only able to review and discuss the first group of recommendations. In general, each submitted set of workgroup recommendations was structured as an integrated approach to improving the legislation. As a result, the process of grouping all submitted recommendations into common issue areas or content categories and then discussing some, but not all, was difficult. Still, the three themes that surfaced during the workgroup process as principal discussion items – quality and the definition of quality indicators, pay-for-performance, and data collection and reporting – proved central in the various perspectives, interests, and positions of different stakeholder groups with regard to issue areas and specific recommendations.

Issue areas not uniquely addressing these themes predominantly garnered workgroup member support across the three stakeholder groups. These issue areas included: improving cost reporting methodology; reducing the lag time in facility expenditures and reimbursement; staff training; transitioning residents to the community and assisting in meeting Olmstead requirements; addressing the audit system/process; and developing a system for defining, collecting and reporting data on quality of care and quality of life in skilled nursing facilities. Two recommendations, one from the issue area of improving cost reporting methodology, and one from the issue area of cost reimbursement – timing, had unanimous support: *Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology (p. 26)*; and *Address the time lag of facilities increasing costs and recognition of these costs in Medi-Cal reimbursement rates (p. 40)*. Despite the very important development of consensus on these recommendations and common ground in general on this group of issue areas, time constraints limited the group’s ability to address different perspectives with regard to the specific recommendations in each issue area, as well as how best to implement change in the area.

As issue areas and recommendations touched more specifically on the areas of quality and the definition of quality indicators, pay-for-performance, and the required elements of a new data collection and reporting system (e.g., management fees), members of the stakeholder groups expressed differing perspectives. These issue areas included: payroll reporting, staffing standards, the Labor-Driven Operating Allocation, the Liability Insurance Pass-Through, staff turnover and retention, and management fees. Reaching consensus on specific measures or recommendations in not only these but all issue areas was difficult, and by the conclusion of the workgroup, appeared to be beyond the scope of the workgroup at this time. It should be noted that even in these issue areas there were intersections of agreement and interest among some workgroup members to continue these discussions, in some form, in the future. By the end of the workgroup process, many members indicated that although the process had been difficult, they found the opportunity to understand different stakeholder perspectives and receive important information and data both valuable and positive. In the absence of more developed recommendation proposals at this time, the State is encouraged to continue efforts to improve the timeliness of AB 1629 monitoring, data collection, and reporting.

### **Note**

All of the workgroup’s representatives participated in the process, working both diligently and with integrity to ensure they fulfilled their responsibilities and the charge of the workgroup. It must be recognized that each group is reflective of a diverse composition of interests, with varied knowledge and breadth of experience on the issues of quality of care and reimbursement in California’s nursing homes. Further, each representative group is recognized as advocates for the interests of its constituencies. Members of the workgroup and public were informed at the beginning of the process that all submitted recommendations, as well as supporting information and comments regarding the recommendations, would be included in this report. None of the submitted material was reviewed or vetted for factual accuracy or edited by the author. Prior to finalization of this summary report, the document was submitted in draft form to the Department of Health Care Services for review. The draft was then sent to members of the Workgroup and public for feedback. The author and the Department carefully considered all recommended edits and suggestions and incorporated much, but not all, of the feedback into the final report; however, additional recommendations comments were accepted and incorporated as submitted.

## I. Introduction

California changed its nursing home Medicaid reimbursement methodology following passage of the Medi-Cal Long Term Care Reimbursement Act of 2004 (AB 1629). The impetus behind AB 1629 was a desire by multiple stakeholder groups, and the State, to address a confluence of issues and factors challenging the viability of the skilled nursing facility industry. Chief among these issues were: the need to establish and promote a financially stable skilled nursing facility industry; and, the need to address ongoing challenges with low staffing and retention levels, high staff turnover, and facility complaints and deficiencies. During the two-year period prior to AB 1629, the skilled nursing facility industry had experienced several significant financial challenges: escalating operating costs for new staffing requirements; higher workers' compensation insurance and liability insurance costs; and, the challenge of a Medi-Cal rate reimbursement freeze.

AB 1629 required the California Department of Health Care Services (DHCS) to develop a cost-based reimbursement rate methodology for skilled nursing facilities (SNFs). The rate methodology developed by DHCS computes a facility-specific, cost-based per diem payment for SNFs based on the sum of five different cost categories (see Appendix A: AB 1629 Background):

1. **Labor:** This category has three components: direct resident care labor costs; indirect care labor costs; and a labor-driven operating allocation.
  - Direct resident care labor costs include salaries, wages and benefits related to routine nursing services personnel defined as nursing, social services and activities personnel. These costs are limited to the 90<sup>th</sup> percentile of each facility's peer group.
  - Indirect care labor costs include all labor costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. These costs are limited to the 90<sup>th</sup> percentile of each facility's peer group.
  - Labor-driven operating allocation (LDOA) includes an amount equal to 8 percent of direct and indirect resident care labor costs, less expenditures for agency staffing such as nurse registry and temporary staffing costs. The LDOA cannot exceed 5 percent of the facility's total Medi-Cal reimbursement. Facilities can use the LDOA for allowable Medi-Cal expenditures incurred caring for Medi-Cal residents. The LDOA was initially proposed by the provider community. It is essentially a profit margin that links annual return to labor costs, creating an incentive for facilities to fund staffing and wages for both direct care nursing staff and indirect care. The LDOA was included in the rate methodology based on an industry and union assumption that appropriate staffing levels result in high quality patient care.
2. **Indirect care non-labor:** This category includes the non-labor costs related to services that support the delivery of resident care including: the non-labor portion of nursing;

housekeeping; laundry and linen; dietary; in-service education; pharmacy consulting costs and fees; and plant operations and maintenance costs. These costs are limited to the 75<sup>th</sup> percentile.

3. **Administrative:** This category includes allowable administrative and general expenses of operating the facility including: administrator costs; business office costs; home office costs that are not directly charged; and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. These costs are limited to the 50<sup>th</sup> percentile.
4. **Fair rental value system (FRVS):** This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.
5. **Direct pass-through:** This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance, and new state and federal mandates including the facility's portion of the QAF.

Categories are subject to cost limits, and costs specific to one category may not be shifted to another cost category to circumvent the limits, which are set based on expenditures within geographic peer groups. The specific intent of AB 1629 was: to provide reimbursement to skilled nursing facilities that support quality improvement efforts; to establish a reimbursement methodology that encourages and rewards skilled nursing facilities to invest more in direct care labor; to impose a quality assurance fee to enhance federal financial participation; and to encourage capital investment.

Since its implementation, several evaluative reports have assessed the efficacy of the legislation in several key domains, the *Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality and Costs* (Harrington et al., April 2008)<sup>i</sup> and *Evaluation of AB 1629* (Schnelle et al 2008)<sup>ii</sup>. Comprehensively evaluating outcomes of the new rate system, however, has been challenging for numerous reasons, including a sunset provision in the bill, the significant lag time between facility spending and cost reimbursement, and timely availability of facility and cost report data. To continue efforts to both evaluate and enhance the legislation, the Health Trailer Bill of 2008 (AB 1183), contained several provisions related to AB 1629, chief among them the establishment of a stakeholder workgroup, of interested stakeholders, to make recommendations to the California Department of Health Care Services to ensure compliance with the intent of AB 1629, as detailed in the legislation (subdivision (a) of Section 14126.02).

The workgroup, comprised of 18 members representing consumers/advocates, skilled nursing facility labor, and skilled nursing facilities, together with representatives from the state departments of Health Care Services, Public Health, the Office of Statewide Health Planning and Development, and the Office of the State Long-Term Care Ombudsman met seven times from November 2008 through January 2009. The responsibility of the workgroup was to provide AB

1629/ratesetting methodology recommendations to the Department of Health Care Services, responsible, in turn, for submitting the workgroup recommendations to the Legislature by March 1, 2009. Note: this summary report is intended to be a reflection of the workgroup process, discussion content, and outcomes; it is not the statutorily mandated Department of Health Care Services' AB 1629 Recommendations report to the Legislature. This report includes the following: an overview of the process; AB 1629/ratesetting methodology recommendations submitted and voted on by workgroup members, with comments by workgroup members; and appendices of supporting workgroup documents. The workgroup process was supported by funding from the California HealthCare Foundation, based in Oakland, California.

## II. Workgroup Process: Overview

Several key stakeholder groups were absent from the development of AB 1629, as well as from the bill's legislative proceedings. Since the bill's implementation however, a number of formal and informal efforts have been made to reopen dialogue among stakeholder groups interested in evaluating and improving aspects of the bill. Under AB 1183, and with the intent of the Legislature, three distinct stakeholder groups, consumers/advocates, skilled nursing facility labor, and skilled nursing facilities, were encouraged to form a workgroup to consider the structure of, and potential changes to AB 1629's facility-specific ratesetting system (AB 1629, Section 14126.023) that may improve the quality of resident care. Workgroup members were further encouraged to consider a wide-range of factors deemed relevant to ensure the quality of resident care for the purpose of developing AB 1629/ratesetting methodology recommendations through a collaborative process.

The California Department of Health Care Services (DHCS) convened the first workgroup meeting on November 6, 2008. Each of the three stakeholder groups, consumers/advocates, skilled nursing facility labor, and skilled nursing facilities, identified six representatives to participate on the workgroup. As noted, representatives from DHCS, the State Department of Public Health, the Office of Statewide Health Planning and Development, and the Office of the State Long-Term Care Ombudsman joined the 18-member workgroup, as non-voting members. Members met seven times during a three-month period. A neutral facilitator, independent of DHCS and any of the stakeholder groups, facilitated the meetings. Members of the public – consumers, advocates, providers, additional representatives from state departments and legislative staff members – were invited to attend the meetings in person and via a conference call-in line. At designated times, the public was invited to share comments, ask questions, etc. Assistive services, including but not limited to, sign-language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of training or meeting materials into Braille, large print, audiocassette, or computer disk, were offered to individuals with disabilities, upon request.

### Meeting Schedule

Workgroup meetings were held at the University of Southern California State Capitol Center, 1800 I Street, Sacramento, California. DHCS disseminated information regarding the meetings and workgroup documents to members and the public through e-mails and postings on the workgroup website: [www.dhcs.ca.gov/services/medi-cal/Pages/SNFQualityWorkgroup.aspx](http://www.dhcs.ca.gov/services/medi-cal/Pages/SNFQualityWorkgroup.aspx)

- November 6, 2008, 9:30 A.M. – 12:30 P.M.
- November 19, 2008, 10:15 A.M. – 3:15 P.M.
- November 24, 2008, 10:15 A.M. – 3:15 P.M.
- December 1, 2008, 10:15 A.M. – 3:15 P.M.
- December 17, 2008, 10:15 A.M. – 3:15 P.M.
- January 12, 2009, 10:15 A.M. – 3:15 P.M.
- January 22, 2009, 10:15 A.M. – 3:15 P.M.

The following elements chronicle the workgroup process: member participants, workgroup themes, and meeting highlights.

## **Workgroup Members**

### ***Consumers/Advocates***

- ***Geneva Carroll***, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- ***Mike Connors***, California Advocates for Nursing Home Reform (CANHR)
- ***Deborah Doctor***, Disability Rights California
- ***Nancy Hall***, Disability Services and Legal Center
- ***Nina Weiler-Harwell***, AARP\*\*
- ***Bill Powers***, California Alliance for Retired Americans (CARA)\*\*
- ***Betty Perry***, Older Women's League (OWL)\*\*
- ***Gary Passmore***, Congress of California Seniors (CCS)\*\*

\*\* Represents the four rotating members of Consumers/Advocates stakeholder group: only two members of this rotating group were represented at the table at any one time.

### ***Skilled Nursing Facilities***

- ***Lori Costa***, Aging Services of California
- ***David Farrell***, SNF Management
- ***Jim Gomez***, California Association of Health Facilities (CAHF)
- ***Jocelyn Montgomery***, California Association of Health Facilities (CAHF)
- ***Darryl Nixon***, California Association of Health Facilities (CAHF)
- ***Michael Torgan***, Country Villa Health Services

### ***Skilled Nursing Facility Labor***

- ***Corinne Eldridge***, SEIU United Long Term Care Workers (SEIU ULTCW)
- ***Dionne Jimenez***, SEIU International
- ***Mary Mundy***, Member, SEIU United Healthcare Workers West (SEIU UHW)
- ***Tamara Rasberry***, SEIU CA State Council
- ***Deb Roth***, SEIU United Long Term Care Workers (SEIU ULTCW)
- ***Richard Thomason***, SEIU United Healthcare Workers West (SEIU UHW)

The four state department representatives participating on the workgroup, and the workgroup facilitator, are listed below.

### ***State Representatives and Facilitator***

- ***Toby Douglas***, Department of Health Care Services (DHCS)
- ***Ty Christensen***, Office of Statewide Planning and Development (OSHPD)
- ***Pam Dickfoss***, California Department of Public Health (CDPH)
- ***Joe Rodrigues***, State Long-Term Care Ombudsman, California Department of Aging
- ***Monique Parrish***, Facilitator

## ***A. Workgroup Themes***

The abbreviated time frame for the AB 1629 workgroup and the predefined goal of developing AB 1629/ratesetting recommendations, set the stage for members to participate in a dedicated process of exploring and discussing different perspectives and experiences regarding the legislation. While stakeholder differences required the group to dedicate much of their attention to establishing a fair and open process with adequate structure for discussing and vetting information, rich content discussion equally characterized the meetings. This section details three issue themes, which surfaced during the meetings,

Among the many issues discussed by workgroup members, several emerged repeatedly, inspiring engaged discussion and debate albeit no specific resolution or final determination. These included the definition and measures of quality, pay-for-performance, and data collection and reporting.

### **Quality**

A robust discussion on nursing facility quality indicators and their definitions revealed multiple perspectives and experiences regarding the issue of quality. Some members asserted that quality is largely associated with staffing ratios, wages, and benefits; others affirmed that achieving quality is contingent on the interdependency of multiple factors, chief among them resident, staff, and family satisfaction. The group discussion inspired members to subsequently submit, for workgroup reading, research, reports, and journal article citations addressing various dimensions of quality. The conclusion of the discussion was workgroup consensus that the following issue areas merited further attention (note: the workgroup did not address which among the list represented quality indicators):

- Higher Staffing
- Decrease Staff Turnover/ Increase Staff Retention.
- Measure Resident Satisfaction
- Reduce Lag Time in Ratesetting to 12 Months or Less
- Up-To-Date Payroll Data
- Improve Data Collection

### **Pay-for-Performance**

Although Pay-for-Performance (P4P) was discussed early, and several times later, in the workgroup process, the issue was characterized by a general lack of consensus among members regarding its definition and scope. During the early discussion, various presentation options addressing P4P were introduced and considered; however, members expressed different perspectives on the value of the presentations. While several members of the workgroup expressed interest in a P4P system, others expressed reservations about moving toward this system, citing the absence of an infrastructure to support it. This lack of consensus led the group to table P4P as a discussion issue in favor of focusing on other issue areas.

Later in the process when recommendations were developed, several members noted that a number of the recommendations employed a P4P approach despite the workgroup's earlier

decision to remove it from active discussion. Members of the provider stakeholder group affirmed their support for P4P but reported they did not develop recommendations for several reasons: first, it was their understanding that it was no longer a viable issue for the group; second, they felt that it was inappropriate to do so in the absence of foundational discussions on how P4P functions in other health sectors and in skilled nursing systems in other parts of the country; and third, they believed there was not agreement, at a minimum, on the definition and scope of P4P. Other members indicated they were confused by the outcome of the earlier discussion and understood that P4P was only temporarily suspended from discussion. Several members reported they did not perceive the tabling resolution as an agreement that stakeholders could not make recommendations to tie payment to staffing or wage increases. After an extensive discussion, the workgroup chose not to schedule additional workgroup meetings to revisit the P4P issue but rather to move forward to conclusion. Members interested in submitting P4P recommendations were encouraged to do so.

### **Data Collection and Reporting**

Members identified a wide-range of data information requests from the state departments of Health Care Services (including Audits and Investigations, Medi-Cal Benefits, Waiver Analysis and Rates Division), Public Health (Licensing and Certification), Office of Statewide Planning and Development, Office of the State Long-Term Care Ombudsman. Information requests were organized by the following categories:

- General
- Staffing
- Quality of Care
- Cost
- Olmstead

Staff from state departments providing information responses worked assiduously to retrieve and present data. Sample information requests and questions included:

1. *How much money is collected annually by the QAF?*
2. *Is there a robust and reliable data system in place where the pertinent metrics can be measured, tracked, trended and correlated so that decisions about quality can be made based on factual evidence?*
3. *How many total days were SNFs understaffed since AB 1629 took effect what is the value of this understaffing by peer group? What is the value, by peer group, of staffing over the 3.2 per-patient-per-day requirement?*
4. *By year, what is the total number of complaints filed against skilled nursing facilities that are subject to the 1629 rate system?*
5. *By year, what is the total number of federal deficiencies issued to skilled nursing facilities that are reimbursed under the 1629 rate system?*
6. *Provide details of annual aggregate Medi-Cal spending for SNF care (including subacute) since 1629 took effect. How much has spending increased?*

7. *What percent of budget has gone to various home and community-based services categories?*
8. *How is CDPH measuring the extent to which residents who had expressed a preference to return to the community were able to do so, as required by W&I Code section 14126.033 (C)(4)(B)? What process did CDPH use to establish its methodology?*

A significant amount of data and information was shared with workgroup members; however, not all information requests and questions were answered. The process illuminated efforts by state personnel to administer and monitor AB 1629; it also revealed the need for a more comprehensive and effective data collection and reporting system to improve the lag time between facility expenditures and cost reimbursement and to more effectively evaluate the new ratesetting system.

## ***B. Meeting Highlights***

Establishing and maintaining a structured process, while simultaneously addressing complicated and substantive issues, presented a singular challenge for the workgroup. Further complicating this natural tension were strong differences among stakeholder groups and a fast track for developing recommendations. As a result, meetings vacillated between process and content. During the first few meetings, members defined the workgroup's purpose, primary goal, supporting objectives, and a decision making structure for resolving differences. Subsequently, members identified the information and data they needed to make recommendations and discussed and debated factors associated with ensuring the quality of resident care. The following meeting highlights address both process and content developments. The minutes from each meeting, which provide more detailed information, and all documents referenced in italics are posted on the workgroup website [www.dhcs.ca.gov/services/medical/Pages/SNFQualityWorkgroup.aspx](http://www.dhcs.ca.gov/services/medical/Pages/SNFQualityWorkgroup.aspx).

(Also see Appendix B: Workgroup Information Documents and Presentations).

### **Meeting I. November 6, 2008**

- DHCS provided an overview of AB 1629
- Members identified the following protocol (ground rules) for workgroup interaction:
  - Focus on evidence-based (fact-based) quantitative and qualitative information
  - Stay on point
  - Inclusion rather than exclusion
  - Maintain a big-picture perspective
  - First establish principles and values then process
  - Respect each other
- The Bagley-Keene Open Meeting Act Procedures were presented: members were asked to respect the open meeting, notice, and agenda provisions of the law.
- Members elected to: 1) have a neutral facilitator for the workgroup process; and 2) forego subgroups due to time constraints and the need for an open process.

### **Meeting II. November 19, 2008**

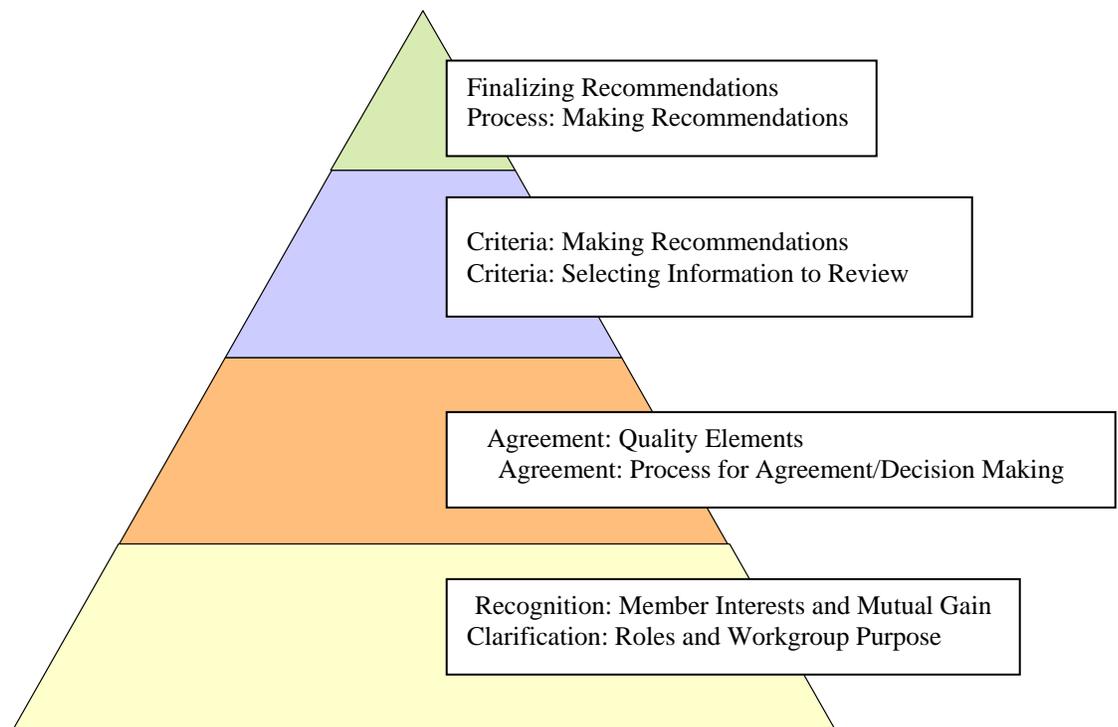
- Members identified the following workgroup purpose, primary goal, and supporting objectives:
  - Workgroup Purpose: The AB 1629 workgroup, representing diverse stakeholders, has the responsibility of developing AB 1629/ratesetting methodology recommendations for the Department of Health Care Services (DHCS), pursuant to W&I Code Section 14126.02(a), and may take into consideration all factors deemed relevant to ensure the quality of resident care.
  - Goal: To develop AB 1629 ratesetting methodology recommendations.
    - Objective #1: Identify information needed to make recommendations.

- Objective #2: Define a process for reviewing information and making recommendations.
- Objective #3: Establish a process for reviewing final set of recommendations for workgroup summary report with public impact.
- Workgroup members and stakeholder groups shared principles and values.
- Members identified a large group of information requests organized by category: general, staffing, quality of care, cost, and Olmstead.
- The following presentation options were discussed: the Centers for Medicare and Medicaid Services (CMS) to address payroll data and pay-for-performance pilot studies; and, research on resident and staff satisfaction from My InnerView.

**Meeting III. November 24, 2008**

- An AB 1629 Workgroup Process Pyramid served as a framework for the workgroup’s efforts, beginning with clarification of workgroup roles and purpose and ending with finalizing recommendations.

**AB 1629 Workgroup Process Pyramid**



- Members constructively addressed each layer of the pyramid, albeit not chronologically. Members confirmed they were the issue experts and owners of the process and outcomes. They identified several key benefits to working together as a group:

1) The workgroup has an opportunity to submit recommendations to improve AB 1629; 2) The collective experience and expertise of workgroup members is significant and all opinions should be heard and considered, including minority opinions; 3) The workgroup process gives members an opportunity to understand each other's interests; and 4) The process is not a zero-sum game, as such, it gives workgroup members an opportunity to work together to craft outcomes.

- Members agreed to a decision-making process, promoting reaching consensus (which may or may not be unanimous) whenever possible, followed by a majority-minority voting system.
- Members reviewed the first draft of the *AB 1629 Workgroup Questions* document. The document listed submitted information requests, the appropriate state department to respond, whether the information was available, and the date when the information would be provided to the workgroup. Department presentations were scheduled to begin at the 12/1/08 meeting.

#### **Meeting IV. December 1, 2008**

- A rich discussion on nursing facility quality indicators inspired members to share their experiences and perspectives, as well as contemporary research and literature articles addressing quality. The conclusion of the discussion was workgroup consensus that the following issue areas merited further attention (note: the workgroup did not address which among the list represented quality indicators):
  - Higher Staffing
  - Decrease Staff Turnover/ Increase Staff Retention.
  - Measure Resident Satisfaction
  - Reduce Lag Time in Ratesetting to 12 Months or Less
  - Up-To-Date Payroll Data
  - Improve Data Collection
- Pay-for-performance (P4P) was subsequently discussed by the group. Several members of the workgroup expressed an interest in a P4P system; others expressed reservations, citing the absence of an infrastructure to support a P4P system. The workgroup agreed to table the discussion and focus on other elements to measure, where data was readily available to the group.
- CDPH reported on efforts to obtain an early release of their report: *Staffing and Quality of Care Indicators in Skilled Nursing Facilities, Report to the Legislature*; DHCS presented responses to some department information requests.
- Members scheduled the following presentations for the 12/17/08 meeting.
  - Presentation by CMS on the payroll data project.
  - Presentation by workgroup member, David Farrell, on satisfaction surveys.
  - Presentation by CHHS/DHCS on Olmstead and the California Community Choices project.

## **Meeting V. December 17, 2008**

- The following presentations were made:
  - Megan Juring, Assistant Secretary of CA Health and Human Services Agency – Olmstead Activities, and colleagues, presented an overview of California’s Community Transition and Community Choices Initiatives and Changes to the Minimum Data Set (MDS).
  - David Farrell, SnF Management, provided an overview of the key issues associated with nursing home resident, family, and staff satisfaction and the relationship between these measures and the quality of resident care in nursing homes.
  - Jim Matthews and John McCraw, DHCS, Rates Branch, presented data on cost category spending/reimbursements, QAF amounts due/collected, adult freestanding subacute rates/reimbursements, and how freestanding skilled nursing facility rates have compared to certain inflation indices since 2001.
  - Dr. Andrew Kramer, Head, Division of Health Care Policy and Research, University of Colorado Denver (via phone) presented findings from CMS’s four-year research pilot addressing payroll specifications and quality measures in nursing homes.
  - Mike Harrold and Emilee Hogg, DHCS Audits and Investigation (A&I), provided an overview of the audit process and addressed workgroup questions.
  - Pam Dickfoss and Gina Henning, CDPH highlighted key findings from the report, *Staffing and Quality of Care Indicators in Skilled Nursing Facilities, Report to the Legislature*, and answered member information requests.
  - Joe Rodrigues, State Long-Term Care Ombudsman, California Department of Aging, provided an overview of his handout, *Nursing Home Complaints by National Ombudsman Reporting System Categories* and responded to member questions.
- Members identified the following criteria as guidelines for developing recommendations:
  - Consonant with AB 1629 Workgroup Purpose
  - Includes an Analysis and Justification
  - Measures Impact
  - Addresses Costs
  - Assesses Feasibility of Implementation

## **Meeting VI. January 12, 2009**

- Findings from phone-based information gathering interviews, conducted by the facilitator with workgroup members during the early part of the workgroup process, revealed that 1) improving quality of care and quality of life for all nursing home residents, and 2) improving the State’s nursing home data collection and reporting processes represented

common ground interests for workgroup members (see Appendix C: AB 1629 Workgroup Information-Gathering Interviews).

- Ty Christensen, Office of Statewide Planning and Development (OSHPD), presented a 16-page handout addressing data requests and questions for OSHPD. The handout included detailed graphs summarizing skilled nursing facility and sub-acute care only nurse staffing hours per day and hourly rates (statewide and by peer group), employee turnover, nursing labor costs per patient day (statewide and by peer group), routine care costs, and costs statewide in the areas of administration, activities, social services, dietary, housekeeping, and nursing in-service. Graphs addressing additional financial ratios were also included (e.g., operating margin, current ratio, long-term debt to asset rate, return on assets, etc.). (The handout can be accessed at: [www.dhcs.ca.gov/services/medi-cal/Pages/SNFQualityWorkgroup.aspx](http://www.dhcs.ca.gov/services/medi-cal/Pages/SNFQualityWorkgroup.aspx)).
- The P4P issue was revisited when several members noted that a number of the recommendations employed a P4P approach, despite the workgroup's earlier decision to take P4P off the table. The workgroup chose not to schedule additional meetings to revisit the issue but rather to move forward: members interested in submitting P4P recommendations however were encouraged to do so.
- The following workgroup members presented their submitted recommendations, and letter, and responded to member requests for explanation and clarification:
  - SEIU – (Recommendations)
  - Older Women's League, Congress of California Seniors, California Alliance for Retired Americans – (Letter)
  - Congress of California Seniors - (Recommendations)
  - California Advocates for Nursing Home Reform, Ombudsman & Health Insurance Counseling and Advocacy Program Services of Northern California, Disability Rights California, Disability Services and Legal Center, AARP - (Recommendations)
  - California Association of Health Facilities, Aging Services of California, Country Villa Health Services, SnF Management – (Recommendations)
- Workgroup members agreed to have submitted recommendations organized into a baseline document for review at the final meeting scheduled for January 22, 2009

### **Meeting VII. January 22, 2009**

- The *AB 1629 Workgroup Recommendations Document* was presented to workgroup members in advance of the final meeting. The document organized recommendations into three sections. Section I - common issue areas with multiple recommendations equaling 11+ member representation support; Section II - common issue areas with multiple recommendations equaling 7-10 member representation support; and, Section III - issue areas with recommendations that did not overlap with those proposed by one or more of the other groups. Members voted their interest in and/or support for issue areas and recommendations in Sections I and II. Members subsequently submitted votes on

Section III, as well as comments on issue areas and recommendations for all three sections, electronically.

### III. Stakeholder Recommendations

Workgroup members submitted AB 1629/ratesetting methodology recommendations for group review at the January 12, 2009 workgroup meeting. The recommendations were subsequently organized into thematic issue areas and grouped by the number of recommendations received for a specific issue area. After several iterations, the final set of AB 1629 workgroup recommendations was organized into two subsections: Issue Areas with Multiple Recommendations (subsection A); and Additional Workgroup Recommendations – non-overlapping recommendations – organized by four broad content categories (subsection B). The specific issue areas/content categories by subsection are listed below:

#### **A: Issue Areas with Multiple Recommendations**

1. Cost Reporting/Cost Methodology
2. Cost Reimbursement – Timing
3. Staff Training
4. Payroll Reporting
5. Staffing Standards RNs/LVNs
6. Transitioning Residents to the Community and Assisting in Meeting Olmstead Requirements
7. Labor-Driven Operating Allocation
8. Liability Insurance Pass-Through
9. Staff Turnover/Retention
10. Audit System/Process
11. Management Fees
12. Develop a system for defining, collecting and reporting data on quality of care and quality of life in skilled nursing facilities

#### **B: Additional Workgroup Recommendations (By Category)**

1. Reimbursement/Ratesetting/QAF Methodology
2. State Processes and Procedures
3. Research, Study, Data Collection and Reporting
4. Licensure, Oversight, and Enforcement

Each issue area and recommendation includes a general and individual vote; the latter listed by representative stakeholder group. Key stakeholder perspectives associated with each issue area and related recommendations in subsection A are also presented (because of time constraints, the workgroup was only able to discuss this subsection as a group). Additionally, recommendations include supporting information (analysis, justification, etc.) from the submitting organization(s) and comments. SEIU, the provider stakeholder group, and California Advocates for Nursing Home Reform (CANHR) together with the Ombudsman and Health Insurance Counseling and Advocacy Program (HICAP) of Northern California submitted general as well as specific comments regarding AB 1629 recommendations. Specific comments are included with the respective issue area or recommendation; general comments are presented below. Note: members of the public and workgroup were invited to submit recommendations and comments outside the workgroup process – one recommendation was submitted and is presented as the last recommendation in the additional workgroup recommendations subsection.

### **Recommendations Evaluation Process**

Prior to evaluating and developing recommendations, workgroup members were asked to consider the following as it related to each recommendation or specific subcomponent: 1) Was the recommendation within the workgroup’s principle mandated charge of developing recommendations related to the AB 1629 rate methodology that further improve and continue to ensure the quality of resident care 2) Was the recommendation justified and supported by both factual data and reasonable analysis; 3) Could the recommendation be measured; 4) Did the recommendation have a cost impact, and if so, what was the estimated cost impact; 5) What was the feasibility of implementing the recommendation; and 6) If the recommendation’s evaluation did not meet the above criteria, did it have merit but needed more research and study before it could be fully evaluated?

### **Note**

All of the workgroup’s representatives participated in the process, working both diligently and with integrity to ensure they fulfilled their responsibilities and the charge of the workgroup. It must be recognized that each group is reflective of a diverse composition of interests, with varied knowledge and breadth of experience on the issues of quality of care and reimbursement in California’s nursing homes. Further, each representative group is recognized as advocates for the interests of its constituencies. Members of the workgroup and public were informed at the beginning of the process that all submitted recommendations, as well as supporting information and comments regarding the recommendations, would be included in this report. None of the submitted material was reviewed or vetted for factual accuracy or edited by the author. Prior to finalization of this summary report, the document was submitted in draft form to the Department of Health Care Services for review. The draft was then sent to members of the Workgroup and public for feedback. The author and the Department carefully considered all recommended edits and suggestions and incorporated much, but not all, of the feedback into the final report; however, additional recommendations comments were accepted and incorporated as submitted.

## Voting Workgroup Members

### ***Consumers/Advocates***

- ***Geneva Carroll***, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- ***Mike Connors***, California Advocates for Nursing Home Reform (CANHR)
- ***Deborah Doctor***, Disability Rights California
- ***Nancy Hall***, Disability Services and Legal Center
- ***Nina Weiler-Harwell***, AARP
- ***Bill Powers***, California Alliance for Retired Americans (CARA)\*\*
- ***Betty Perry***, Older Women's League (OWL)\*\*

\*\* Only one member of this rotating group voted at any one time.

### ***Skilled Nursing Facilities***

- ***Lori Costa***, Aging Services of California
- ***David Farrell***, SNF Management
- ***Jim Gomez***, California Association of Health Facilities (CAHF)
- ***Jocelyn Montgomery***, California Association of Health Facilities (CAHF)
- ***Darryl Nixon***, California Association of Health Facilities (CAHF)
- ***Michael Torgan***, Country Villa Health Services

### ***Skilled Nursing Facility Labor***

- ***Corinne Eldridge***, SEIU United Long Term Care Workers (SEIU ULTCW)
- ***Dionne Jimenez***, SEIU International
- ***Mary Mundy***, Member, SEIU United Healthcare Workers West (SEIU UHW)
- ***Tamara Rasberry***, SEIU CA State Council
- ***Deb Roth***, SEIU United Long Term Care Workers (SEIU ULTCW)
- ***Richard Thomason***, SEIU United Healthcare Workers West (SEIU UHW)

Four organizations submitted recommendations and are referenced by the designated acronym or listing next to their recommendations:

- Congress of California Seniors = (CCS)
- California Advocates for Nursing Home Reform (CANHR), AARP, Disability Rights California, Ombudsman & HICAP Services of Northern California, Disability Services and Legal Center = (C/A – for Consumers/Advocates)
- California Association of Health Facilities, Aging Services of California, Country Villa Health Services, SnF Management = (Providers)
- Service Employees International = (SEIU)

## **General Comments**

### ***SEIU (Submitted 1/12/09)***

#### **Background**

The quality of care provided in California nursing homes remains unacceptably low. Too often the frailest and most vulnerable seniors and the disabled fail to get high quality nursing home care. The evidence presented to the Nursing Home Stakeholder Workgroup shows that in recent

years some important quality metrics have shown slow improvement. Too many others have shown no improvement or give evidence of declining quality of care. This is intolerable in a period during which the profit margin of California nursing homes has increased substantially.

Continuing problems with the quality of nursing home care in California are shown by the following:

- Increasing numbers of complaints made to the state's Long-Term care Ombudsman and to the Department of Public Health, despite a declining number of nursing home admissions and a flat trend in Medi-Cal patient days. From 2002-03 to 2006-07, the number of complaints to the Long-Term Care Ombudsman rose by 16 percent. From 2004 to 2007 the number of complaints to the Department of Public Health rose by almost 14 percent, while the number of substantiated allegations rose by 77 percent. The total number of state citations issued to nursing homes rose by 48 percent from 2004 to 2007.
- According to a 2008 report by the Office of the Inspector General of the federal Department of Health and Human Services, the percentage of California nursing homes surveyed that received federal deficiency notices rose from 98.6 percent in 2005 to 99.1 percent in 2007, and the average number of deficiencies found per surveyed facility rose from 10.2 to 11.8. California had a higher proportion of nursing homes with deficiencies in 2007 (99.1%) than the national average of 91.9 %, and a higher average number of deficiencies per facility, 11.8, than the national average of 7.<sup>iii</sup>
- The recent release of the five-star rating system by the federal Centers for Medicare and Medicaid Services (CMS) also illustrates the overall quality problems of California nursing homes: over 44 percent of California nursing homes were rated worse than average (having one or two stars out of five). California ranked 23<sup>rd</sup> out of 51 states and the District of Columbia on having the highest proportion of facilities with one star while ranking 36<sup>th</sup> in the proportion of facilities that had five stars.

According to the Office of Statewide Health Planning and Development (OSHPD), the operating margin for SNFs rose from 0.02 % in 2003 to 4.38 % in 2007. According to an SEIU analysis of state Medi-Cal rates, the average Medi-Cal per diem (not including the QAF) rose 31 % in five years from 2003-04 to 2008-09 (from \$118.04 to \$154.09). Clearly AB 1629 and subsequent increases in the state budget for Medi-Cal payments to nursing homes have played a key role in improving the profitability of the nursing home industry.

However, this enhanced profitability has yet to make significant improvements in staffing. The evidence shows that staffing has increased too slowly to make a sufficient change in nursing home quality. The CDPH report shows that the mean nursing hours per patient day in facilities audited rose from 3.31 in 2002-03 to 3.46 in 2006-07, a 4.5 % increase. Although the proportion of facilities complying with the current inadequate minimum staffing standard of 3.2 hours per patient day has risen since 2002-03, the CDPH survey of facility staffing in 2006-07 found that 69 percent of facilities were out of compliance on at least one of the days audited. Facilities staffed below the minimum requirement on 17 percent of days in 2006-07.

Employee turnover, while dropping in recent years, is also still too high. Although turnover fell in recent years, in 2007 annual turnover for nursing employees was still over 50 percent.

Consistent, person-centered care simply cannot be provided by a workforce that is continually changing. Turnover is lowest in the peer group – peer group 7, the Bay Area – with among the highest wages, the highest levels of staffing and the most unionization. Much of this turnover is due to the fact that in recent years earnings for nursing assistants, after inflation, have stayed flat - according to the CDPH report, inflation-adjusted earnings (wages, salaries and benefits) for nursing assistants actually declined slightly, from \$10.08 in 2001-02 to \$10.02 in 2007-08.

***SEIU (Submitted 2/6/09)***

SEIU appreciates the opportunity to have participated in the AB 1629 Workgroup. We value the time the various departments, stakeholders, and members of the public took to discuss these important issues. The workgroup received a lot of valuable information, and many recommendations have emerged. It is unfortunate that only a small subset of recommendations received unanimous votes. In some instances this reflected broad ideological differences, but we believe that in other instances the ideological gaps appear to be minor, and we might have developed additional consensus recommendations if given more time to discuss the substance of an issue. We are optimistic that further work with stakeholders in the coming months will yield more positive changes.

SEIU has been involved with reforming the Medi-Cal reimbursement system for a number of years, from sponsoring AB 1075 in 2001, which mandated the shift to a facility-specific reimbursement system, to being a chief proponent of AB 1629. Nearly 5 years later we are disappointed in the lack of significant improvements in resident quality of care for the industry as a whole. This workgroup has been an important step as we try to improve the system. We hope the department and legislature consider many of these recommendations and move forward with implementation. We appreciate the opportunity to comment and look forward to further improving the Medi-Cal reimbursement system, resident quality of care, and quality of life for residents and staff.

***Providers (Submitted 2/6/09)***

**General Comments**

The AB 1629 Workgroup (workgroup) established by Welfare and Institutions Code 14126.02(a) was charged with the responsibility of developing recommendations related to the AB 1629 rate methodology that could work to further improve and continue to ensure the quality of resident care. In that regard, it is important when developing recommendations that the workgroup be open to broader ideas and concepts, but in the end, confine such recommendations to the statutory scope of its charge. More specifically, the charge of developing recommendations related to the AB 1629 rate methodology that further improve and continue to ensure the quality of resident care. It is in that vein that the workgroup's provider representatives participated and worked to ensure they fulfilled their responsibilities. Unfortunately, the workgroup's diverse composition of interests, varied experience, and breadth of knowledge and understanding about the AB 1629 reimbursement methodology and related State agency operating practices, made reaching consensus during the recommendation review and deliberation process difficult. In some cases there were clearly areas of common ground, and in others there was solid disagreement. Although, there were areas where agreement was reached on general principles and importance, there were also areas of disagreement relating to the specifics of a

recommendation or its subcomponents. Because of this, the workgroup's provider representatives believe it is important to clarify their position and provide comments on the recommendations they could not support as outlined within this document.

### **Recommendations Evaluation Process**

When evaluating the recommendations, the workgroup's provider representatives considered the following as it related to each recommendation or specific subcomponent: 1) Was the recommendation within the workgroup's principle mandated charge of developing recommendations related to the AB 1629 rate methodology that further improve and continue to ensure the quality of resident care; 2) Was the recommendation justified and supported by both factual data, and reasonable analysis; 3) Could the recommendation be measured; 4) Did the recommendation have a cost impact, and if so, what was the estimated cost impact; 5) What was the feasibility of implementing the recommendation; and 6) If the recommendation's evaluation failed in meeting the above criteria, did it have merit but needed more research and study before it could be fully evaluated?

### ***California Advocates for Nursing Home Reform (CANHR), AARP, Disability Rights California and Ombudsman Services of Northern California (Submitted 1/12/09)***

Under AB 1629, annual Medi-Cal spending on skilled nursing facility care has increased by about \$1 billion and average rates have increased by 37 percent.<sup>iv</sup> Of that \$1 billion in new spending, only \$282 million comes from the Quality Assurance Fee;<sup>v</sup> the remainder comes from the California General Fund and federal funds.

Despite the enormous infusion of taxpayer funds, AB 1629 has not achieved its intent of ensuring individual access to appropriate long-term care services, promoting quality resident care, advancing decent wages and benefits for nursing home workers, supporting provider compliance with all applicable state and federal requirements, and encouraging administrative efficiency.

Some skilled nursing facility operators have used the increased funding to improve care and staffing; many others have not.

Key indicators suggest that the quality of care has declined, not improved, since AB 1629 was enacted. For example:

- Public complaints to DPH rose from 8,694 in 2004 to 13,691 in 2007, a 57 percent increase.<sup>vi</sup>
- The number of complaint allegations that DPH substantiated expanded from 1,493 in 2004 to 2,638 in 2007, a 76 percent increase.<sup>vii</sup>
- The number of facility reported incidents received by DPH rose from 7,438 in 2004 to 13,207 in 2007, a 77 percent increase.<sup>viii</sup>
- The number of facility reported allegations to DPH related to resident abuse more than doubled from 1,839 in 2004 to 4,542 in 2007.<sup>ix</sup>
- The number of facility reported allegations that DPH substantiated more than tripled from 931 in 2004 to 3,284 in 2007.<sup>x</sup>

- Findings of immediate jeopardy, actual harm and substandard quality of care grew from 551 in 2004 to 845 in 2007, a 53 percent increase.<sup>xi</sup>
- The number of citations DPH issued to skilled nursing facilities rose from 471 in 2004 to 698 in 2007, a 48 percent increase.<sup>xii</sup>
- The number of AA citations for violations that directly led to a resident's death more than doubled from 11 in 2004 to 23 in 2007.<sup>xiii</sup>
- In December 2008, the federal Centers for Medicare and Medicaid Services (CMS) rated 551 California nursing facilities (44%) as being much below average or below average based on inspection findings, staffing levels and quality measures.<sup>xiv</sup>

To achieve its objectives, AB 1629 must be reformed to ensure that Medi-Cal spending is directed to care, services and staffing that directly benefit skilled nursing facility residents. This is especially urgent in the budget crisis. The following recommendations serve that purpose.

***CANHR and Ombudsman & HICAP Services of Northern California (Submitted 2/6/09)***

**General Comments on Provider Recommendations**

The provider recommendations would tweak the reimbursement system rather than provide the broad reforms that are necessary. Their recommendations do not acknowledge or address the central problems with the AB 1629 reimbursement system.

Despite boosting Medi-Cal payments to skilled nursing facilities by about \$1 billion per year, complaints, facility abuse reports, deficiencies and citations have increased since AB 1629 was enacted and implemented. There have only been marginal increases in staffing levels, and a large number of SNFs still fail to meet minimum staffing requirements on an annualized basis. Wages to nursing assistants haven't even kept pace with the cost-of-living. Medi-Cal beneficiaries' access to nursing home care has not improved. The huge investment in nursing home care appears to be coming at the expense of long overdue development of a more comprehensive home and community-based service system.

The provider recommendations do not meaningfully address any of these concerns.

Instead, they would perpetuate the status quo by continuing the lucrative labor driven operating allocation – which pays skilled nursing facilities an 8 percent bonus on top of their labor costs – with no strings attached. The nearly \$200 million spent annually on this bonus should be redirected to a greatly needed increase in California's minimum staffing requirements.

## ***A. Issue Areas with Multiple Recommendations***

### **1. Issue Area: Cost Reporting/Cost Methodology**

#### **General Vote Record**

Yea: 18

Nay: 0

Abstention: 0

#### **Individual Vote Record**

18 Yeas

##### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

##### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

##### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### **Key Stakeholder Perspectives**

Improving AB 1629 cost reporting mechanisms and methodology was unanimously supported by the workgroup. Differences existed however regarding the exact approach and design of a new viable cost reporting system.

- Providers recommend improving and updating the current Medi-Cal free-standing skilled nursing facility cost reporting methodology to allow for increased efficiency during both the audit and rate setting process and to allow costs to be specifically identified and segregated within the appropriate AB 1629 cost component category (i.e., segregating

liability, workers compensation, health insurance costs). They do not support duplicative reporting requirements regarding management fees.

- \* Members of the Consumers/Advocates stakeholder group recommend specifically capturing management fees to corporate offices and other corporate office costs in the new cost reporting system; they also recommend that cost reports be synchronized with the AB 1629 rate system.
- SEIU recommends redesigning the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report to collect additional relevant information that will assist the rate setting process and improve analysis of the impact of the Medi-cal reimbursement system.

## **Comments**

### ***SEIU***

SEIU is pleased that all of the workgroup members agreed that the cost reporting methodology should be updated and improved. However, we could not reach consensus on what additional relevant information should be collected in Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report in order to better and more accurately analyze the impact of the new Medi-Cal reimbursement system and improve industry transparency. We encourage the department and OSHPD to consult with interested stakeholders to identify additional data collection items and discuss implementation.

### ***Providers***

The workgroup's provider representatives are also pleased that the general recommendation that the Long Term Care Facility Integrated Disclosure and Medi-Cal Cost Report be re-designed was adopted unanimously. It must be noted that the workgroup's provider representatives rejected a number of the subcomponent recommendations. The reason and rationale for rejecting these subcomponent recommendations are enumerated in separate comments provided under the subcomponent.

\* Note: the wording, *Members of the Consumers/Advocates Stakeholder Group*, typically references a majority of Consumer/Advocates stakeholder members but not necessarily all.

## **Recommendations**

*i. Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology. (Providers)*

### **General Vote Record**

Yea: 18

Nay: 0

Abstention: 0

### **Individual Vote Record**

18 Yeas

#### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

## **Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** The current Medi-Cal cost report follows the OSHPD requirements, which have been in place for years. While the report requires the reporting of all costs, the current report does not allow for proper segregation of costs consistent with the AB 1629 reimbursement methodology. For example, liability, workers compensation, nor health insurance costs are specifically segregated or identified separately in the current cost report. These costs are aggregated within other broad categories such as administration and employee benefits. For example, in order to identify and break out costs such as liability insurance, providers are required to submit

supplemental cost data. In the absence of supplemental cost data, DHCS audit staff are required to identify the liability costs during the audit process. In order to ensure that the AB 1629 rate is calculated appropriately, the costs have to be re-classified by segregating them from the administration cost category. The cost report needs to be updated and improved to ensure that providers properly report costs within the proper cost categories consistent with the AB 1629 reimbursement methodology. Updating the cost report will allow for increased efficiency during both the audit and rate setting process as costs will be specifically identified and segregated within the appropriate AB 1629 cost component category. This will eliminate the need for supplemental reporting of this information and time spent by audit staff to identify and break out costs from other broad cost categories.

**Pros:**

- Eliminates need for ongoing supplemental reporting.
- Improves transparency in the cost reporting process by specifically identifying certain costs currently reported in broad cost categories.
- Improves efficiency in the audit and rate setting process.

**Cons:**

- Requires DHCS and OSHPD to develop and implement new cost report or to augment current reporting process.
- Current provider Medi-Cal cost reporting will change.

**Impact:** The impact of this recommendation can be measured internally by DHCS through workload analysis in both the Financial Audits Branch and Medi-Cal AB 1629 Rate Development Unit. The efficiencies gained can be measured in reduced audit time spent to segregate costs from broad categories, elimination of supplemental cost reporting requirements, and reduction of rate setting errors that result in provider requests for review and correction.

**Costs:** Initial costs to develop a new report and establish a system to collect and assimilate the data for rate setting and public disclosure. These costs can be offset by fees paid to OSHPD or Quality Assurance Fees paid by free-standing skilled nursing providers. Costs to develop a new report and system are likely in the range of \$150,000 to \$300,000.

**Feasibility:** This is a recommendation of immediate importance to ensuring the overall goals of AB 1629 are met and can be sustained. Given that costs can be offset through fees with no general fund requirement, there should be no true impediment to implementing this recommendation with the exception of internal workload priorities within OSHPD and DHCS.

*ii. Require facility cost reports to specifically capture management fees to corporate offices and other corporate office costs. (C/A)*

**General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

**Individual Vote Record**

12 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
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- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) – C/A**

The Audits and Investigation Division reports that it cannot identify these costs because these expenses are not captured separately on the audit report or the cost report.<sup>xv</sup> This oversight should be corrected so that Medi-Cal can determine when corporations are diverting funds intended for care.

## **Comments**

### ***Providers***

Providers voted six (6) Nays.

The workgroup's provider representatives support transparency and disclosure however this recommendation is duplicative of reporting requirements currently in place. Specifically, the Office of Statewide Health Planning and Development's (OSHDPs), Long Term Care Accounting and Reporting Manual includes separate accounts for recording management fees paid to both related and unrelated organizations.

iii. *Require cost reports to be synchronized with the AB 1629 rate system. (C/A)*

**General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

**Individual Vote Record**

12 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
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- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Nays

6 Skilled Nursing Facilities

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- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) – C/A**

The Audits and Investigation Division reports that it is unable to provide meaningful information on audit disallowances or audit adjustments because of "the inherent limitations of using the audit as a medium to convert reported data designed for a flat rate prospective rate methodology into the current rate system."<sup>xvi</sup> It also describes complicated steps auditors must take to reclassify costs due to this same problem. The cost reports should be designed for the current rate system, not the system replaced by AB 1629.

## **Comments**

### ***Providers***

Providers voted six (6) Nays.

The nay vote by the workgroup's provider representatives is not reflective of disagreement with the recommendation that cost reports need to be synchronized with AB 1629 rate setting.

However, this recommendation is duplicative of recommendation A. 1. *i.*, “*Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology*”, which was approved unanimously, and therefore unnecessary.

*iv. Redesign the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report. (SEIU)*

**General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

**Individual Vote Record**

12 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Skilled Nursing Facility Labor

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- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) - SEIU**

The Department and OSHPD in consultation with interested stakeholders should redesign the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report in order to collect additional relevant information that will assist the rate setting process and improve analysis of the impact of the Medi-Cal reimbursement system. The following items are examples of what should be included in the new form:

- Productive hours and salaries should be reported by straight-time, overtime, and double-time in order to more accurately know the average hourly wages of employees;
- Benefits should be separated by type: health, dental, vision, paid time off, etc.;
- More transparency of facility ownership and operations;
- More detail provided for liability insurance related costs;
- More detail on staff turnover;
- More detail on Patient Days census (report bed hold days and Medicare Managed Care days; separately, report patient days by type of service: SNF vs. Residential care);
- Report legal fees, payments due to citations/penalties; and
- More detail for home office costs and management fees.

## **Comments**

### ***Providers***

Providers voted six (6) Nays.

The nay vote by the workgroup's provider representatives is not reflective of disagreement with the general recommendation that the Long Term Care Facility Integrated Disclosure and Medi-Cal Cost Report be re-designed. In fact, recommendation A. 1. i., "*Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology*", was approved unanimously. The nay vote reflects rejection of the specifics contained in the recommendation's subcomponent which is prescriptive. Provider representatives strongly support and agree that the Long Term Care Facility Integrated Disclosure and Medi-Cal Cost Report be re-designed, but would recommend a more open process for re-design as opposed to prescriptive recommendations offered by any representative group.

## 2. Issue Area: Cost Reimbursement – Timing

### General Vote Record

Yea: 18

Nay: 0

Abstention: 0

### Individual Vote Record

18 Yeas

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
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- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

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- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
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- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

### Key Stakeholder Perspectives

Throughout the AB 1629 Workgroup process, reducing the lag time in facility expenditures and reimbursement earned universal support from members.

- Members of the Consumers/Advocates stakeholder group support shortening the lag time. Several individual members of this group further stated the change should be done in a budget neutral manner and in consideration of the system CMS is establishing to collect payroll data.

- SEIU recommends a payroll data reporting system that provides data for the purpose of developing labor cost information for the rates, to accelerate the recognition of labor costs in a facility's Medi-Cal rates and reduce the current two-year lag between the time a facility incurs a cost and when it receives a concomitant increase in its Medi-Cal rate.
- Providers recommend advancing the timing for cost recognition. They note that although the AB 1629 reimbursement system provides limited working capital in the Labor Operating Allocation (LOA) rate component to offset some advanced costs, continuously rising operating costs and other economic factors dilute the effectiveness of the LOA as a true source of working capital.

## **Comments**

### ***Providers***

The workgroup's provider representatives fully support the overarching recommendation that the time lag between the costs facilities incur and when the costs are recognized in the AB 1629 rate needs to be addressed. This recommendation is one of the most important and critical recommendations from the workgroup's provider representative perspective. Currently there is an 18-24 month minimum time delay from the time when a facility incurs costs and the time when the costs are recognized in their AB 1629 rate. This significant time lag has impeded more rapid progress in achieving AB 1629's overall goals. California's skilled nursing providers understand the need to invest in the workforce and other aspects of care to improve and continue to ensure quality of care, but are reluctant to advance substantial funding and wait 2 years to be reimbursed. Advancing cost recognition in the AB 1629 rate setting process will remove significant existing impediments to in achieving AB 1629's overall goals.

### ***SEIU***

We are encouraged that all workgroup members agreed that efforts should be taken to reduce the current two-year lag between the time a facility incurs a cost and the time a facility receives an associated Medi-Cal rate increase. The department should convene stakeholder meetings at the earliest opportunity to discuss the details of developing a payroll data reporting system to determine labor cost reimbursement and various other options to finally address this problem. Once this issue is resolved, providers will have more of an incentive to invest in their facilities and staff, which will result in improvements in quality of care and life for residents.

## **Recommendations**

- i. Shorten the lag time between facility expenditures and Medi-Cal reimbursement rate adjustments. (CCS)*

### **General Vote Record**

Yea: 0

Nay: 18

Abstention: 0

### **Individual Vote Record**

18 Nays

#### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

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- David Farrell, SNF Management
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- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

## **Supporting Information from Submitting Organization(s) - CCS**

At the present time a facility must wait two years or more to recover the costs of salary adjustments, additional staff, or higher non-labor expenses in their rates. This lag time results from the state's procedures for collecting and verifying data and it creates uncertainty for the facilities which do not know what caps will be in place or what the spending patterns are for their peer groups until well after spending commitments are made. There is anecdotal evidence that this long lag time has made facilities reluctant to commit to new spending in response to the incentives set out in AB 1629, undermining the goals of rate reform.

To shorten the lag time in rate reimbursement, we recommend that the Department of Health Care Services develop a report to the Legislature describing one or more systems for skilled nursing facilities to report staffing information based on additional data, including but not limited to, payroll data in a uniform electronic format that includes whether the employee is a registered nurse, licensed vocational nurse or a certified nurse assistant and that provides daily resident census data. The system or systems should be designed in a manner that would allow the data to be used by DHCS to update Medi-Cal rate reimbursements to skilled nursing facilities for labor-related costs on an annual or semi-annual basis so that expenses incurred in one year (prior to December 31) are reflected in rates set no later than the following year (in August). The report should include recommendations for reporting and analyzing non-labor costs in a similar time frame. It should also include cost estimates to the state and to the nursing home industry to implement the system(s). If necessary, the system should include post-payment audits and reconciliation procedures. No later than February 15, 2010, the department should seek any necessary legislative changes to implement a reporting and reimbursement system by January 1, 2011. We further recommend that the reporting system be used to generate reimbursement rates for 2012. After the new reimbursement timeline is in place, the impact could be measured by the degree to which facilities respond more fully to the incentives in AB 1629 and by surveying facilities to determine their satisfaction with the shorter reimbursement time lag.

There would be costs to both the state agency and to facilities to develop a new system and to implement the new system, including those incurred by the need for more current data collection and analysis. There could also be a one-time increase in the rates resulting from bringing rates closer to current spending. In the long term, as more facilities experienced faster cost reimbursement, there may be additional costs from greater compliance with funding incentives.

This recommendation can be readily implemented and would further the goals of AB 1629.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

We oppose the recommendation because it ignores the system CMS is establishing to collect payroll data. We support shortening the lag time if done in a budget neutral manner.

#### ***Providers***

The workgroup's provider representatives are pleased that the general issue area on Cost Reimbursement – Timing was identified and supported as an important issue was adopted unanimously. It must be noted that the workgroup's provider representatives rejected a number of the subcomponent recommendations. The reason and rationale for rejecting these subcomponent recommendations are enumerated in separate comments provided under the subcomponent.

*ii. Advance timing for cost recognition when determining annual AB 1629 facility-specific rates. (Providers)*

**General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

**Individual Vote Record**

12 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

**Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** The current 18-24 month time delay in recognizing costs utilized in the AB 1629 annual facility-specific rate setting process impedes progress in achieving the overall goals established by AB 1629 to improve the quality of care in California's skilled nursing facilities. Skilled nursing providers understand the need to invest in their workforce and other aspects of care that will improve quality but are reluctant to advance substantial funding and wait more than 2 years to be reimbursed. Although the AB 1629 reimbursement system provides limited

working capital in the Labor Operating Allocation (LOA) rate component to offset some advanced costs, continuously rising operating costs and other economic factors dilute the effectiveness of the LOA as a true source of working capital. To put this in perspective using the current FY 2008-09 rate cycle as an example, costs incurred during the fiscal periods on or before 12/31/2006 were used to establish the 8/1/2008 AB 1629 facility-specific rates. California skilled nursing providers have varied fiscal years so some facilities that incurred costs beginning July 1, 2005 and continuing through June 30, 2006 will not see these costs recognized in their rate until August of 2008. Further, due to delays in budget passage and AB 1629 facility-specific rate implementation, the actual rate increase may not occur for more than five months with retroactive payment following nearly 8 months later. This is the case with the current AB 1629 rates that were effective in August 2008 where DHCS has indicated that the rates will begin to be updated and paid early in January 2009 with the retroactive adjustments following sometime in March 2009.

Pros:

- Mitigates provider impediments to advancing costs for increased staffing, improving workforce wages and benefits, and improving facility infrastructure.
- Consistent with analysis of recent reports concerning the effectiveness of AB 1629 in meeting established intent.
- Change in timing of cost recognition is budget neutral as established global budget CAPS contain overall costs within the State's Medi-Cal budget parameters.

Cons:

- Advances time frames for state agencies and providers to ensure cost reporting, receipt and review, and audits, are timely and up to date.

**Impact:** The impact of this recommendation can be measured annually through simple analysis of changes in costs reported through OSHPD reporting, provider audits, and the annual rate setting process.

**Costs:** As indicated, implementing this recommendation is budget neutral.

**Feasibility:** This is a recommendation of immediate importance to ensuring the overall goals of AB 1629 are met and can be sustained. Given the budget neutral aspects of the recommendation, the only element that could impede implementation is the ability for the responsible State agencies to ensure more current cost information is available for rate setting.

### Comments

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

Our support for this recommendation is contingent on it being implemented in a budget neutral fashion, as proposed.

*iii. Address the time lag of facilities increasing costs and recognition of these costs in Medi-Cal reimbursement rates. (SEIU)*

**General Vote Record**

Yea: 18

Nay: 0

Abstention: 0

**Individual Vote Record**

18 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
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- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

**Supporting Information from Submitting Organization(s) - SEIU**

A payroll data reporting system can be designed that also provides data for the purpose of developing labor cost information for the rates. This will help accelerate the recognition of labor costs in a facility's Medi-Cal rates and reduce the current two-year lag between the time a facility incurs a cost and when it receives a concomitant increase in its Medi-Cal rate. The Department of Health Care Services Rate Development Branch, Audits & Investigation, and interested stakeholders should also determine whether there are other system changes possible to reduce the time lag and speed up cost recognition in the rates. However, since multiple sources

of information might be used for rate setting it will be important to strengthen the audit process so that when a facility is overpaid for its labor costs it will be required to pay back those funds.

### 3. Issue Area: Staff Training

#### General Vote Record

Yea: 18

Nay: 0

Abstention: 0

#### Individual Vote Record

18 Yeas

##### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
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- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### Key Stakeholder Perspectives

Staff training was well supported as an issue area; however, differences surfaced on the specifics as presented in the recommendations, e.g., the pass-through, training content areas:

- SEIU recommends identifying why so little training is reimbursed through the existing pass-through and what changes can be made to increase reimbursement for staff training, especially for training programs created through contractual arrangements with a joint labor-management Taft-Hartley fund.

- Providers recommend redefining and expanding the caregiver training pass-through component to a 100% pass-through for all training to nursing home staff for cost effective training programs directed toward improving quality; they also support DHCS's analyzing the Care Giver Training Pass-Through cost component to understand why it is not fulfilling its intended purpose.
- Members of the Consumers/Advocates stakeholder group support assessing underutilization of the current pass-through for caregiver training before expansion is considered – they also support including cultural, linguistic, and disability competency training with training opportunities for employee advancement, RN and LVN training, and dietary training.

## **Comments**

### ***SEIU***

All workgroup participants, including the SEIU representatives, recognize the importance of staff training as an issue. We are concerned that the proposal of a 100% pass-through for all training, as offered by providers, is overly broad. We hope that discussions will continue after the conclusion of the workgroup process to identify other workable solutions and we hope that all stakeholders will work with us to identify why so little training is reimbursed through the existing caregiver training pass-through. We are open to working towards development of a better design for the caregiver training pass-through component.

### ***Providers***

The workgroup's provider representatives are pleased that the general issue area of Staff Training was identified as being critically important and adopted unanimously. It must be noted that the workgroup's provider representatives may have rejected subcomponent recommendations. The reason and rationale for rejecting these subcomponent recommendations are enumerated in separate comments provided under the subcomponent.

## **Recommendations**

- i. Expand and redefine the caregiver training pass-through component to a 100% pass-through for all training to nursing home staff, which is directly related to the quality of resident care and services. Require the California Department of Public Health Licensing and Certification Program to review survey and Quality Measure data at least once a year in order to identify and recommend priority-training topics for skilled nursing staff. (Providers)*

### **General Vote Record**

Yea: 6

Nay: 5

Abstention: 7

### **Individual Vote Record**

6 Yeas

#### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

5 Nays

#### **5 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP

7 Abstentions

#### **1 Consumers/Advocates**

- Bill Powers, California Alliance for Retired Americans (CARA)

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

## **Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** As the acuity of nursing home residents increases and the standards of Gerontological services, workforce retention, and leadership practices continue to be more refined, the importance of on-going training becomes more and more critical in the skilled nursing setting. Currently the training cost component in AB 1629 only covers training received by direct care staff and only if that training leads to a formally recognized license or certificate such as Certified Nursing Assistant. The current system does not provide reimbursement for formal in-service training on relevant topics directly related to the quality of resident care and services. It does not reimburse for “career ladder” training such as the Restorative Aid program, which allows CNAs to become specialized in assisting in therapy programs. It does not cover leadership, communication, quality improvement or workforce retention training for administrators or nursing directors. The current cost component in AB 1629 needs to be redefined so that the costs of appropriate education at all levels of facility personnel are reimbursed at a reasonable level.

**Impact:** Review of data from the Department of Health Services indicates that all peer groups have underutilized the Caregiver Training Per Diem allotment since the implementation of AB 1629. The expansion and redefinition of allowable costs under this cost category is expected to incentivize providers to fully utilize this reimbursement category. The second feature of this recommendation; that is to required the Dept of Public Health, Licensing and Certification to identify training priorities for providers based on current survey and Quality Measure Data could result in improved participation of providers in training opportunities that address those priorities. It also establishes a proactive approach to quality improvement in this state that is not tied to enforcement actions that kick-in after care deficits, and possibly negative resident outcomes, have occurred.

**Relevance to AB 1629:** The redefinition and expansion of the rate-setting mechanism for training and education will support the efforts of skilled nursing providers to maintain a highly trained and competent workforce, and so has direct relevance to the intent of AB 1629 to ensure the quality of resident care.

**Feasibility:** This modification is highly feasible, and could be implemented with policy revision, education, and possibly memorandums of agreement with the Dept of Health Services, Licensing and Certification to provide the training recommendations annually. The recommendation is budget neutral as total State expenditures are controlled within global budget CAPS. However, it could result in a re-distribution of the portion of reimbursement directed to this rate component both in the aggregate and within individual facility-specific rates.

## **Comments**

### ***CANHR and Ombudsman & HICAP Services of Northern California:***

The current pass-through for caregiver training is not working. Its underutilization should be assessed before any expansion is considered. CAHF and ASC – not DPH – should be reviewing survey and quality measure data and recommending training topics to SNF staff.

*ii. The department and interested stakeholders should work to identify why so little training is reimbursed through this pass-through and to identify the changes that can be made to increase reimbursement for staff training, especially for training programs created through contractual arrangements with a joint labor-management Taft-Hartley fund. These programs can include training unique to the long-term care industry that supports opportunities for employee advancement, RN and LVN training, and dietary training – also to include cultural, linguistic, and disability competency training.<sup>xvii</sup> (SEIU)*

### **General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

### **Individual Vote Record**

12 Yeas

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

#### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

### **Supporting Information from Submitting Organization(s) - SEIU**

Better training results in a more satisfied and productive workforce and improves quality care. However, the total amount of the rate reimbursed in the caregiver training pass-through dropped from \$2 million in 07-08 to \$1 million in 08-09. The department and interested stakeholders should work to identify why so little training is reimbursed through this pass-through and to identify the changes that can be made to increase reimbursement for staff training, especially for training programs created through contractual arrangements with a joint labor-management Taft-Hartley fund. These programs can include training unique to the long-term care industry that support opportunities for employee advancement, RN and LVN training and dietary training.

### **Comments**

#### ***Providers***

Providers voted six (6) Nays.

The workgroup's provider representatives support the need for the Department of Health Care Services (DHCS) to review and analyze this issue in order to identify possible explanations for why the Care Giver Training Pass-Through cost component is not fulfilling its intended purpose. Additionally, the workgroup's provider representatives support the need to consider clarifying and expanding the definition of the Care Giver Training Pass-through cost component to ensure clarity and to expand opportunities for pass-through reimbursement for cost effective training programs directed toward improving quality. The workgroup's provider representatives do not support this particular recommendation as it seeks to prescribe training content to providers without any supporting evidence that such training is directly linked to quality.

#### 4. Issue Area: Payroll Reporting

##### General Vote Record

Yea: 12

Nay: 6

Abstention: 0

##### Individual Vote Record

12 Yeas

###### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

###### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

###### Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

##### Key Stakeholder Perspectives

Payroll reporting, as a mechanism for determining staffing levels, engendered mixed responses from workgroup members. SEIU and consumers/advocates strongly supported recommendations in this area, while providers expressed a different perspective:

- Providers support the premise that all California skilled nursing facilities meet staffing requirements, but disagree with the recommendation to require payroll reporting to

determine compliance. They note that reporting and using payroll information to determine compliance with staffing requirements would be burdensome, cost prohibitive, and duplicative of established reporting and systematic review processes already in place, including the annual survey process.

- Members of the Consumers/Advocates stakeholder group recommend the Legislature establish a reporting system that requires facilities to provide complete daily reporting, by shift, for all types of staff from payroll records under the current reporting system, to facilitate timely assessment of the rate system's impact, enforce staffing requirements, and provide the public with critical information about nursing home care.
- SEIU recommends requiring payroll data reporting for purposes of enforcement of staffing requirements and more updated labor cost reporting into the rate system – they indicate that payroll data will enable Licensing and Certification to better enforce staffing standards and ensure that facilities are living up to their obligation to provide quality care to their residents.

## **Comments**

### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. While the workgroup's provider representatives strongly support the premise that all California skilled nursing facilities meet staffing requirements, we disagree with the recommendation to require payroll reporting to determine compliance. Reporting and using payroll information to determine compliance with staffing requirements would be burdensome and cost prohibitive. Additionally, it would be duplicative of established reporting and systematic review processes already in place including the annual survey process. For example, payroll related information is the basis for staffing and wage information required to be reported to the Office of Statewide Health and Development annually. (This information is validated as part of the financial audit process performed by the Department of Health Care Services (DHCS)). Further, the California Department of Public Health (CDPH) has established and implemented a separate AB 1629 staffing compliance review process apart from the annual survey process that also utilizes payroll data as the basis of staffing determinations. Lastly, a system of tracking staffing through payroll data reporting is currently being developed by the Federal government (CMS). Taking this issue on at the state level would be duplicative and cost prohibitive.

### ***SEIU***

We were encouraged by the 12 votes in favor of using payroll reporting to determine staffing levels. Despite the lack of consensus in the workgroup, we hope the state works with CMS and closely monitors their pilot program. Our current method of tracking staffing levels in this state needs significant improvement, and a payroll reporting system is one of the most promising options.

## **Recommendations**

- i. Require skilled nursing facilities to report staffing information from payroll records on a quarterly basis. (C/A)*

### **General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

### **Individual Vote Record**

12 Yeas

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

#### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

### **Supporting Information from Submitting Organization(s) – C/A**

Medi-Cal is spending several billion dollars each year on nursing home care but doesn't have a suitable reporting system to determine whether it is achieving the desired results. For example, under the current reporting system, the state does not learn about nursing home staffing levels until almost two years after the fact. The very long delays prevent timely assessment of the rate

system's impact, inhibit enforcement of the staffing requirements and deprive the public of critical information about nursing home care.

The Legislature should fix this problem by establishing a reporting system that requires facilities to provide complete daily reporting, by shift, for all types of staff from payroll records. The reports should be submitted quarterly using a standard electronic format and facilities should be required to certify their accuracy under penalty of perjury. Quarterly reporting of payroll data already maintained by nursing homes would enable California to improve the enforcement of minimum staffing requirements, provide the public timely and accurate information about nursing home staffing levels, and expedite adjustment of Medi-Cal rates.

The Centers for Medicare and Medicaid Services (CMS) is devising a payroll-based staffing report system for national use and has invested years of research on this system.<sup>xviii</sup> California should coordinate development of its system with CMS and work together with CMS to ensure that the reporting system can be adapted to collect cost data in addition to information on staffing levels.

The Legislature should direct DPH to routinely use information from this system, once it is established, to enforce California's minimum staffing requirements during licensing inspections and investigations carried out under SB 1312 (Alquist, 2006). Currently, there is only token enforcement of minimum staffing requirements.

DPH reports that it issued a total of 43 citations for insufficient staffing during FYs 05-06, 06-07, and 07-08, all but one at the "B" level with maximum fines of \$1,000.<sup>xix</sup> The marginal enforcement occurred despite continued widespread violations of the minimum staffing requirements. DPH reports that only 26 percent of skilled nursing facilities fully complied with the minimum staffing requirements during FY 05-06 and 31 percent of SNFs fully complied in FY 06-07.<sup>xx</sup> DPH audits of a random sample of skilled nursing facilities found that they staffed below the minimum requirements on 23 percent of days in FY 05-06 and 17 percent of days in FY 06-07,<sup>xxi</sup> meaning skilled nursing facilities likely failed to meet minimum staffing requirements on more than 100,000 instances during these two years. OSHPD estimates the value of the understaffing during 2005-2007 to exceed \$34 million.<sup>xxii</sup>

The Legislature should also direct DPH to post staffing information from this system, once it is established, on its consumer information website so that consumers can obtain accurate, up-to-date information on nursing home staffing levels.

## **Comments**

### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. While the workgroup's provider representatives strongly support the premise that all California skilled nursing facilities meet staffing requirements, we disagree with the recommendation to require payroll reporting to determine compliance. Please refer to the Provider comments found on page 48 of this report.

*ii. The state should require payroll data reporting for purposes of enforcement of staffing requirements and more updated labor cost reporting into the rate system. (SEIU)*

**General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

**Individual Vote Record**

12 Yeas

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) - SEIU**

The state should require payroll data reporting for purposes of enforcement of staffing requirements and more updated labor cost reporting into the rate system. Payroll data reporting to DHCS will ensure that the state is getting the most timely and accurate data about staffing. This data will enable Licensing and Certification to better enforce staffing standards and ensure that facilities are living up to their obligation to provide quality care to their residents. The

Department of Health Care Services and the Department of Public Health should work with CMS to move ahead in implementing this requirement in California.

**Comments**

***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. While the workgroup's provider representatives strongly support the premise that all California skilled nursing facilities meet staffing requirements, we disagree with the recommendation to require payroll reporting to determine compliance. Please refer to the Provider comments found on page 48 of this report.

## 5. Issue Area: Staffing Standards RNs/LVNs

### General Vote Record

Yea: 12

Nay: 6

Abstention: 0

### Individual Vote Record

12 Yeas

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

#### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

### Key Stakeholder Perspectives

The issue of staffing standards elicited varying perspectives on specific direct care staff hours and whether AB 1629 was working as intended with regard to increasing staffing levels.

- Members of the Consumers/Advocates stakeholder group recommend increasing minimum staffing requirements from 3.2 to 3.5 hours per resident day (hprd) and

requiring that at least 1.0 hprd be provided by licensed nurses (LVNs or RNs), with no less than 0.5 hprd by registered nurses.

- SEIU recommends translating the current standard of 3.2 hours per patient day into specific minimum ratios for licensed nurses and CNAs; raising the minimum 3.2 standard to 3.5 hours per patient day; and, mapping out how to progress toward the 4.1 minimum standard recommended by advocacy groups and others.
- Providers believe that the staffing reimbursement mechanism in AB 1629 is working as intended and is facilitating the gradual increase in staffing levels within skilled nursing facilities.

## **Comments**

### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The workgroup provider representatives strongly believe that the staffing reimbursement mechanism in AB 1629 is working as intended and is facilitating the gradual increase in staffing levels within skilled nursing facilities. The statewide average for direct care staff hours per patient per day has increased from 3.33 hours in 2004 to 3.57 hours in 2007, exceeding the state minimum requirement of 3.2 and the national average of 3.36. As discussed under the recommendation concerning Cost Reimbursement Timing and later in this document under Other Issue Areas –State Processes and Procedures, workgroup provider representatives strongly believe that removing the lag time of 2 years for cost reimbursement and giving the providers the security of making AB 1629 permanent, removes reimbursement timing barriers to increasing wage and staffing levels. Lastly, workgroup provider representatives do not support or see the necessity to implement the staffing ratios required by Health and Safety Code Section 1276.65. Mandated staffing ratios are unnecessary, arbitrary, expensive, and fail to take into account patient acuity and the unique program and population needs of a specific facility. The staffing reimbursement mechanism contained within AB 1629 labor cost component was specifically designed to adequately compensate facilities for the actual cost of the numbers and types of staff required to meet the care needs of their facility-specific resident population.

### ***SEIU***

It is unfortunate that the workgroup members could not agree that improving staffing standards is an important issue. Despite the lack of a consensus recommendation, it is important to note that SEIU and consumer groups support increasing the minimum staffing requirement and implementing the SNF nursing staff-to-patient ratios. We encourage the department to convene meetings with stakeholders to discuss this important issue, especially the topics of:

- Methodology for estimating the costs for staffing ratio implementation and increasing the minimum staffing hours per patient day (hppd);
- Whether the current reimbursement system and anticipated funding through 2011 provide sufficient resources to implement the staffing ratio regulations that were finally issued on January 22, 2009 or to increase the 3.2 hppd standard to at least 3.5 hppd;

- How funds are appropriated to facilities to meet these requirements; and
- A study to determine appropriate minimum hppd for licensed nurses

SEIU believes that stronger requirements for better staffing must be the foundation to improving nursing home quality in California.

Improve Compliance with Minimum Staffing Requirements: Although there was no consensus recommendation in this area, all workgroup members expressed that they do not condone any facility staffing below the 3.2 hppd minimum staffing level. The current compliance system is not working due to the difficulty in tracking staffing levels and the lack of monitoring unless there is a complaint or an inspection. SEIU believes that the reimbursement system should be part of encouraging compliance with minimum staffing requirements and also act as an incentive to encourage higher staffing levels. This should be balanced with enforcement. (See SEIU's compliance-related comments in the areas of Payroll Reporting, Labor Driven Operating Allocation, and Licensure, Oversight, and Enforcement)

## **Recommendations**

- i. Create a new state minimum staffing standard for registered nurses in skilled nursing facilities – we recommend a .32 hour pp/pd standard for RNs. (CCS)*

### **General Vote Record**

Yea: 0

Nay: 11

Abstention: 7

### **Individual Vote Record**

11 Nays

#### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

#### **5 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP

7 Abstentions

#### **1 Consumers/Advocates**

- Bill Powers, California Alliance for Retired Americans (CARA)

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

### **Supporting Information from Submitting Organization(s) - CCS**

Research suggests that the presence of registered nurses raises the level of quality care in nursing homes. At present the state has a minimum standard for direct care staff but makes no distinction among the various types of care staff included in the staffing standard.

We recommend a separate standard of hours per patient per day for registered nurses. The state should survey other states' requirements and research literature about staffing of registered nurses and propose an amendment to statute which sets a minimum RN staffing level. As a starting point for discussion, we recommend a .32 hour pp/pd standard for RNs. Given the shortage of registered nurses in some areas of California, we believe establishment of such a standard with any penalties for failure to comply should be delayed until January 2012. Implementation of this recommendation will require the state and the industry to set new regulations and compliance procedures. There is no state cost directly related to this recommendation however, if facilities include more higher-cost staff in their spending, reimbursement rates could increase.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

This proposal could institutionalize the very low RN staffing levels in SNFs, which were at about this level when AB 1629 was enacted and have not increased.

#### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The workgroup provider representatives strongly believe that the staffing reimbursement mechanism in AB 1629 is working as intended and is facilitating the gradual increase in staffing levels within skilled nursing facilities. The statewide average for direct care staff hours per patient per day has increased from 3.33 hours in 2004 to 3.57 hours in 2007, exceeding the state minimum requirement of 3.2 and the national average of 3.36. Please refer to the provider comments found on page 54.

*ii. Increase the minimum staffing requirements from 3.2 to 3.5 hours per resident day (hprd). Of this total, the Legislature should require that at least 1.0 hprd be provided by licensed nurses (LVNs or RNs), with no less than 0.5 hprd by registered nurses. (C/A)*

**General Vote Record**

Yea: 6

Nay: 6

Abstention: 6

**Individual Vote Record**

6 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

6 Abstentions

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

**Supporting Information from Submitting Organization(s) – C/A**

Adequate staffing is the most important factor in improving nursing home quality. Higher staffing hours per resident are strongly associated with better functional status, less weight loss

and dehydration, fewer pressure sores and infections, improved nutritional status, less physical restraint and catheter use, lower hospitalization rates, a higher likelihood of discharge to home and lower worker injury rates.

California's minimum staffing requirement of 3.2 hprd was a modest increase when AB 1107 (Cedillo, Chapter 146, Statutes of 1999) was implemented in 2000, and is increasingly inadequate today due to the rising acuity levels in most nursing homes.

The Legislature has repeatedly recognized the need to increase the minimum staffing levels above 3.2 hprd. AB 1075 (Shelley, Chapter 684, Statutes of 2001) required DHS (now DHCS and DPH) to re-evaluate the sufficiency of the staffing requirements by January 1, 2006 and every five years thereafter. See H&S Code §1276.65(e). The Legislature also enacted H&S Code §1276.7, which declares its intent to increase the minimum staffing requirement to 3.5 hprd or higher by 2004.

California's minimum staffing requirement falls far short of safe staffing levels recommended by experts. A Congressionally ordered study by Abt Associates for CMS (2001) reported that a minimum of 4.1 hprd are needed to keep residents safe from harm.<sup>xxiii</sup> Of this total, .75 RN hours per resident day, .55 LVN hours per resident day, and 2.8 CNA hours per resident day are needed to deliver quality care. According to OSHPD data, California skilled nursing facilities averaged 3.57 hprd in 2007,<sup>xxiv</sup> demonstrating that it is feasible for facilities to meet a 3.5 hprd standard. A 3.5 hprd standard is affordable because Medi-Cal is already paying for staffing that meets or exceeds this standard at many facilities.

California has skeletal licensed nurse requirements for skilled nursing facilities.<sup>xxv</sup> The proposal to require at least 1.0 hprd by licensed nurses is slightly less than current average nurse staffing levels<sup>xxvi</sup> and is equivalent to DPH's current regulatory proposal to require at least one licensed nurse for every eight residents over a 24-hour period.<sup>xxvii</sup>

RN staffing levels in California nursing homes are dangerously low, which is alarming because RN staffing levels are very strongly associated with quality of care. OSHPD reports that skilled nursing facilities averaged 0.32 RN hprd in 2007,<sup>xxviii</sup> less than half of the recommended 0.75 hprd. California skilled nursing facilities have not improved RN staffing since AB 1629 was implemented.<sup>xxix</sup> The proposal to require skilled nursing facilities to provide at least 0.5 RN hprd is a modest step toward reaching the safe staffing levels.

In addition to taking this first step, California should continue to periodically upgrade its minimum staffing requirements until it fully achieves the recommended safe staffing levels. The cost of the proposed increases in the minimum staffing requirement would be funded by the savings from repeal of the labor-driven operating allocation and savings from the other recommendations in Section A.

Strengthening the minimum staffing requirements is the strongest action the Legislature can take to improve the quality of skilled nursing facility care and to reform AB 1629. By funding increased staffing levels rather than operator profits, nursing home residents and workers will directly benefit from the state's investment.

iii. *We recommend the immediate implementation of the staffing ratio regulations required by Health and Safety Code Section 1276.65 to translate the current standard of 3.2 hours per patient day into specific minimum ratios for licensed nurses and CNAs. We also recommend that the Legislature raise the minimum 3.2 standard to 3.5 hours per patient day, as promised in AB 1075, and map out how to progress toward the 4.1 minimum standard recommended by NCCNHR and many researchers and senior advocates. SEIU also recommends that the staffing ratios be implemented without waiting for a specific state appropriation for that purpose. (SEIU)*

**General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

**Individual Vote Record**

12 Yeas

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

## **Supporting Information from Submitting Organization(s) - SEIU**

SEIU believes that stronger requirements for better staffing must be the foundation to improving nursing home quality in California. Too often care is compromised by the simple fact that there is not enough nursing staff on hand to take care of residents' needs. Therefore, we recommend the immediate implementation of the staffing ratio regulations required by Health and Safety Code Section 1276.65 to translate the current standard of 3.2 hours per patient day into specific minimum ratios for licensed nurses and CNAs. We also recommend that the Legislature raise the minimum 3.2 standard to 3.5 hours per patient day, as promised in AB 1075, and map out how to progress toward the 4.1 minimum standard recommended by NCCNHR and many researchers and senior advocates.

SEIU also recommends that the staffing ratios be implemented without waiting for a specific state appropriation for that purpose. AB 1075 was enacted prior to AB 1629, and the new rate system and new funds provided by AB 1629 are more than sufficient to fund the cost of implementing the staffing ratio regulations. When implementing the higher 3.5 hppd standard, DHCS should ensure that any resulting rate increase for facilities is specifically targeted to those facilities that can demonstrate that the higher standard actually imposed new costs to the facility to staff up to the standard, rather than granting an across-the-board increase for all facilities.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

Although we support this proposal, we strongly recommend that the Legislature avoid the DPH regulatory process by establishing specific minimum ratios for licensed nurses and CNAs when it increases the minimum 3.2 hprd standard to 3.5hprd.

#### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The workgroup provider representatives strongly believe that the staffing reimbursement mechanism in AB 1629 is working as intended and is facilitating the gradual increase in staffing levels within skilled nursing facilities. The statewide average for direct care staff hours per patient per day has increased from 3.33 hours in 2004 to 3.57 hours in 2007, exceeding the state minimum requirement of 3.2 and the national average of 3.36. Please refer to the provider comments found on page 54.

6. **Issue Area: Transitioning Residents to the Community and Assisting in Meeting Olmstead Requirements**

**General Vote Record**

Yea: 18

Nay: 0

Abstention: 0

**Individual Vote Record**

18 Yeas

**6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

**6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

**Key Stakeholder Perspectives**

Workgroup members endorsed transitioning residents to the community and meeting Olmstead requirements but differed on their support of specific recommendations.

- SEIU recommends the state take additional steps to facilitate transitioning residents to the community: establish statewide nursing home transition programs; strengthen requirements for discharge planning and hospital-to-home transitional care services;

expand current home and community-based services (HCBS) waiver slots; and, expand the number of the state's existing Aging and Disability Resource Centers.

- Providers support California's models and programs to transition nursing home residents to the community. They also support cost effective home and community based alternatives to nursing facility care and assisting nursing facility resident transition to these settings, when appropriate, but indicate difficulty in understanding how taking funds away from the care of nursing facility residents promotes quality and is consistent with the intent of AB 1629 and the charge and responsibility of the workgroup.
- Members of the Consumers/Advocates stakeholder group recommend the legislature freeze total Medi-Cal spending on skilled nursing facilities at current levels, and use the General Fund savings to address short- and long-term recommendations that bring California into compliance with the Supreme Court's Olmstead decision.

## **Comments**

### ***Providers***

The workgroup's provider representatives voted unanimously along with all workgroup representatives on the importance of this category, however, could not support any of the specific recommendations. Workgroup provider representatives support cost effective home and community based alternatives to nursing facility care and assisting nursing facility resident transition to these settings, when appropriate. Workgroup provider representatives also believe that California has done a better job than most other states in developing and utilizing home and community based alternatives to nursing facility care. Further, California is currently participating in the testing and analysis of specific models and programs designed to ensure access to the appropriate level of long-term care. Several of these models include community transition for nursing facility residents where and when it is appropriate. Lastly, workgroup provider representatives have difficulty in understanding how taking funds away from the care of nursing facility residents promotes quality and is consistent with the intent of AB 1629 and the charge and responsibility of this workgroup.

### ***SEIU***

SEIU believes that making sure people receive care in the setting where they want to be and where that care can be provided is an important hallmark of our workgroup recommendations. We are disappointed that wordsmithing issues prevented unanimous adoption of our recommendation to increase efforts to return nursing home residents to home and community based settings. We are pleased that the recommendation received 12 votes and we look forward to working on its implementation.

## **Recommendations**

### ***i. Adjust for costs associated with the reimbursement methodology and reporting requirements transitioning patients to community based care. (CCS)***

- The Department of Health Care Services will establish a stakeholder group to help it identify and define facility costs associated with transitioning patients to community based care and will establish a level of cost reimbursement at the 95th percentile for facilities within a peer group for patient transition activities.

## **General Vote Record**

Yea: 0

Nay: 11

Abstention: 7

## **Individual Vote Record**

11 Nays

### **5 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP

### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

7 Abstentions

### **1 Consumers/Advocates**

- Betty Perry, Older Women's League (OWL)

### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

## **Supporting Information from Submitting Organization(s) - CCS**

Following the U.S. Supreme Court decision known as Olmstead, the state has established a high priority on the provision of non-institutional long-term care services for persons with disabilities. The admissions process for snf residents allows patients to indicate their desire to receive care in the community and their plans of care are supposed to reflect this goal. At present, there is no systematic reporting of resources devoted to transitioning patients and the costs may be reflected in any of several cost categories with different rates of reimbursement.

To reflect the priority given to compliance with the Olmstead decision, we recommend that the Department of Health Care Services do the following:

- Establish a stakeholder group to help it identify and define those facility costs which are directly related to identifying resident preferences, informing and assisting residents, care plan development, record keeping, and monitoring and providing information on community resources, and other discharge related activities.
- Develop a system for reporting such costs in a new cost category as part of the Medi-Cal rate reimbursement methodology.
- Establish a level of cost reimbursement at the 95<sup>th</sup> percentile for facilities within a peer group for patient transition activities.

We recommend that the analysis leading to a standard reporting system be undertaken in 2009 and legislation enacting the reporting system and change in the rate reimbursement methodology be introduced in time to allow the new methodology to be in place by January 1, 2011. The new cost reimbursement category should be reflected in rates set in August 2012.

There will be administrative costs for the state and facilities to identify/define appropriate activities and create a system of reporting and monitoring costs for this recommendation. Once implemented, there will be additional costs resulting from increasing the reimbursement rate to the 95<sup>th</sup> percentile. If these have been reported as labor costs the increase will be minor (from 90% to 95%). If they have been reported as administrative costs they would nearly double (from 50% to 95%). Actual costs to the state would be determined by the extent to which the change triggered the universal spending cap.

We believe that identifying and reporting costs associated with transitioning patients to community based care will raise the awareness of facilities, policy makers and the public on the degree of compliance with this high state priority. Reimbursing these activities at a high rate will reflect state priority and should encourage facilities to commit necessary resources. The impact of this recommendation should encourage facilities to make a stronger commitment to transitioning activities and be reflected in the reports of spending by the state.

## **Comments**

### ***CANHR and Ombudsman & HICAP Services of Northern California***

Any additional Medi-Cal funds should be directed to community-based providers, not nursing homes, to help long-term residents return to the community.

***Providers***

The workgroup's provider representatives voted unanimously along with all workgroup representatives on the importance of this category, however, cannot support any of the specific recommendations. Workgroup provider representatives support cost effective home and community based alternatives to nursing facility care and assisting nursing facility resident transition to these settings, when appropriate. Workgroup provider representatives also believe that California has done a better job than most other states in developing and utilizing home and community based alternatives to nursing facility care. Lastly, workgroup provider representatives have difficulty in understanding how taking funds away from the care of nursing facility residents promotes quality and is consistent with the intent of AB 1629 and the charge and responsibility of this workgroup.

*ii. Due to the budget crisis, the legislature should freeze total Medi-Cal spending on skilled nursing facilities at current levels, and use the General Fund savings to address short- and long-term recommendations that bring California into compliance with the Supreme Court's Olmstead decision. (C/A)*

**General Vote Record**

Yea: 5

Nay: 13

Abstention: 0

**Individual Vote Record**

5 Yeas

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP

13 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

1 Consumers/Advocates

- Betty Perry, Older Women's League (OWL)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

## **Supporting Information from Submitting Organization(s) – C/A**

### ***Short-term recommendations***

- Restore or prevent cuts to community services used by people who otherwise would use nursing homes.
- Fund entities with proven expertise – including but not limited to independent living centers and Multipurpose Senior Services programs – to provide transition services to nursing home residents who want to return to the community.
- Establish a diversion program modeled after successful programs in other states. For instance, Washington state staff gives residents and patients onsite help in skilled nursing facilities and hospitals to identify options, enroll in community services and to transition from nursing homes.
- Enhance the Home Upkeep Allowance.
- Strengthen enforcement of state and federal discharge planning requirements.<sup>xxx</sup> The state should capture separate data on the MDS preference question at 60 days, 90 days and longer stays. There is no evidence that long-term stay residents are being helped to transition.

### ***Long-term recommendations***

- Examine how other states (e.g., Oregon, Washington, Texas) have rebalanced their long term care systems and budgets to reflect consumer preference for non-institutional care.
- Identify goals for California’s long-term care system that eliminate incentives for institutionalization and establish meaningful choices for consumers.
- Explore whether California can save money by procuring more Medicare funds for nursing home stays, as Connecticut has done.

## **Comments**

### ***Providers***

The workgroup’s provider representatives voted unanimously along with all workgroup representatives on the importance of this category, however, cannot support any of the specific recommendations. Workgroup provider representatives support cost effective home and community based alternatives to nursing facility care and assisting nursing facility resident transition to these settings, when appropriate. Workgroup provider representatives also believe that California has done a better job than most other states in developing and utilizing home and community based alternatives to nursing facility care. Lastly, workgroup provider representatives have difficulty in understanding how taking funds away from the care of nursing facility residents promotes quality and is consistent with the intent of AB 1629 and the charge and responsibility of this workgroup.

*iii. The state should do more to enable community living by establishing statewide nursing home transition programs; strengthening requirements for discharge planning and hospital-to-home transitional care services; expanding our current home and community-based services (HCBS) waiver slots to provide more choices to individuals; and expanding the number of the state's existing Aging and Disability Resource Centers to provide statewide coverage so that every Californian has easy access to information, counseling and program linkage on aging and long-term care support options. (SEIU)*

**General Vote Record**

Yea: 12

Nay: 0

Abstention: 6

**Individual Vote Record**

12 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Betty Perry, Older Women's League (OWL)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Abstentions

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s)**

The quality of long-term care for all Californians will improve when every person in need of such care can choose to receive home- or community-based care if that is the most appropriate setting for that person. Although AB 1629 contained provisions intended to carry out a resident's preference to return to the community, the state should do more to enable community living by establishing statewide nursing home transition programs; strengthening requirements for discharge planning and hospital-to-home transitional care services; expanding our current HCBS waiver slots to provide more choices to individuals; and expanding the number of the state's existing Aging and Disability Resource Centers to provide statewide coverage so that every Californian has easy access to information, counseling and program linkage on aging and long-term care support options.

If this is done correctly, so that the incentive is not just to empty beds but rather to successfully transition residents to the care level that works for them, overall health costs can be reduced and more people will live where they desire. If done incorrectly so that the incentive is not just to empty beds but rather to successfully transition residents to the care level that works for them, overall health costs can be reduced and more people will live where they desire. If done incorrectly, the result will be readmissions and higher acuity. Proper care planning is essential.

### **Comments**

#### ***Providers***

The workgroup's provider representatives voted unanimously along with all workgroup representatives on the importance of this category, however, cannot support any of the specific recommendations. Workgroup provider representatives support cost effective home and community based alternatives to nursing facility care and assisting nursing facility resident transition to these settings, when appropriate. Workgroup provider representatives also believe that California has done a better job than most other states in developing and utilizing home and community based alternatives to nursing facility care. Lastly, workgroup provider representatives have difficulty in understanding how taking funds away from the care of nursing facility residents promotes quality and is consistent with the intent of AB 1629 and the charge and responsibility of this workgroup.

## 7. Issue Area: Labor-Driven Operating Allocation

### General Vote Record

Yea: 12

Nay: 6

Abstention: 0

### Individual Vote Record

12 Yeas

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

#### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

### Key Stakeholder Perspectives

The Labor-Driven Operating Allocation (LDOA) inspired diverse perspectives on how or whether it should be part of AB 1629's labor cost component and reimbursement methodology.

- Providers support the LDOA as an integral component within the AB 1629 labor cost component and note it was designed as an incentive to encourage providers to increase

facility staffing (both nursing staff and other staffing categories) as well as to improve wages and benefits.

- Members of the Consumers/Advocates stakeholder group recommend the LDOA be repealed and savings from the repeal used to pay for an increase in the minimum staffing requirements and to prevent cuts to community-based long-term care services.
- SEIU recommends modifying the LDOA – a part of the LDOA should be contingent on the facility meeting the state’s minimum staffing requirements in the base year; another part would rise in relation to the facility’s staffing – the higher the average hppd level, the higher the labor-driven operating allocation.

## **Comments**

### ***Providers***

The workgroup’s provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The specific recommendations seek to eliminate, modify, or divert the labor driven operating allocation rate component (LDOA), which indicates a lack of a basic understanding of the AB 1629 reimbursement methodology by other workgroup representatives. The LDOA is an integral component within the AB 1629 labor cost component and was designed as an incentive to encourage providers to increase facility staffing (both nursing staff and other staffing categories) as well as to improve wages and benefits. Other workgroup representatives have failed to acknowledge that AB 1629’s payment methodology has had a positive impact on facility staffing levels across the state. The LDOA provides an incentive for facility’s to spend more on staffing and wages by tying the LDOA to the labor costs as part of the calculation of a facility’s Medi-Cal reimbursement rate. Additionally, the LDOA gives providers a small margin of funding that enables them to make investments in higher staffing, wages, and benefits that was unavailable under the old “flat rate” system. Lastly, workgroup provider representatives fully support the need for facility compliance with staffing standards, including the current 3.2 minimum. However, recommending that the LDOA be used as an enforcement tool directed against facilities failing to comply with staffing or other requirements, is not consistent with the LDOA’s original design and intent. Further, such recommendation fails to acknowledge that there is an existing enforcement mechanism available to the CDPH when facilities fail to demonstrate compliance with minimum staffing requirements.

### ***SEIU***

While we could not agree on a LDOA recommendation, SEIU looks forward to working with stakeholders and the state to discuss how to design this bonus payment to incentivize higher staffing levels and encourage compliance with staffing standards.

## **Recommendations**

- i. Revise the Labor-Driven Operating Allocation currently used in Medi-Cal rate reimbursements. Divide LDOA into two parts: one part for meeting state staffing mandates and one part for staffing at levels above the minimum. (CCS)*

### **General Vote Record**

Yea: 0

Nay: 18

Abstention: 0

### **Individual Vote Record**

18 Nays

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

### **Supporting Information from Submitting Organization(s) - CCS**

The current rate reimbursement system includes a “Labor-Driven Operating Allocation” (LDOA) based on the total of direct and indirect labor costs for the base rate year. The net result of this provision is that facilities actually receive reimbursement of up to the 90<sup>th</sup> percentile on labor costs in a peer group plus an additional 8% to offset lower reimbursement levels in non-labor costs and administration. While this has been characterized as “profit” it actually creates profit only when a facility’s actual expenses fall well below their peer group average.

While the LDOA is tied to spending on labor it can actually be used for any purpose at the discretion of the facility (and would be reflected in the appropriate spending category in subsequent rate years).

Based on research showing that staffing levels, especially for direct patient care staff, are strongly positively correlated to quality care, we believe that the LDOA should be more directly aimed at improving staffing levels. Further, we believe that since the LDOA is considered discretionary it should be withheld from facilities that do not meet state mandated staffing levels. Therefore we propose the following:

- 5% of the LDOA should be allocated as at present, however, if a facility fails to meet the minimum of 3.2 hours of direct care staffing pp/pd that facility should not get the LDOA in its rate. We believe that if a facility falls below the state minimum during any month that the LDOA be reduced by 1/12<sup>th</sup> if it falls below that state minimum in any three months the LDOA would be reduced by ¼, etc.
- An additional 5% of LDOA (for a new total of up to 10% of direct and indirect labor costs) would be allocated as follows:
  1. When a facility's direct care staffing exceeds 3.2 hours that facility would receive an LDOA of 6%.
  2. When a facility's direct care staffing exceeds 3.4 hours that facility would receive an LDOA of 7%.
  3. When a facility's direct care staffing exceeds 3.6 hours that facility would receive an LDOA of 8%.
  4. When a facility's direct care staffing exceeds 3.8 hours that facility would receive an LDOA of 9%.
  5. When a facility's direct care staffing exceeds 4.0 hours that facility would receive an LDOA of 10%.
- If a facility's direct care staffing level varied from month to month the rate of LDOA earned would vary by month so that staffing levels, labor cost calculations, and LDOA earned would need to be calculated on a monthly basis.
- We recommend that this new LDOA methodology be amended into statute to take effect on January 1, 2011 and reflected in rates beginning in August 2012.

This approach should make the reimbursement system more responsive to efforts by facilities to increase direct care staffing above state minimums thereby increasing the quality of care. It would reinforce the state mandated minimum of direct care staffing. It would tie some of the rate reimbursement directly to staffing levels (as distinct from changes in wages or benefits). At the same time, it recognizes the value of discretionary funding in the formula for facility managers.

The costs of this recommendation vary depending on the industry's response to the new funding incentives. The elimination of the LDOA for facilities falling below the state staffing minimum will reduce state outlays for those facilities. If, as hoped, the potential loss encourages facilities to maintain minimum staffing there would be little or no cost savings. Reducing the flat LDOA from 8% to 5% for all facilities will also reduce program costs. If, however, the sliding scale of

LDOA encourages facilities to raise staffing levels, the savings will disappear and could add to overall costs as more facilities have higher staffing levels earning an LDOA over 8%. This recommendation would require creating a new method for tracking staffing levels and setting rates and may be complex to administer until the state and snfs become familiar with the methodology.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

The LDOA should be repealed and the money directed to better purposes, per our recommendations.

#### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The specific recommendations seek to eliminate, modify, or divert the labor driven operating allocation rate component (LDOA), which indicates a lack of a basic understanding of the AB 1629 reimbursement methodology by other workgroup representatives. The LDOA is an integral component within the AB 1629 labor cost component and was designed as an incentive to encourage providers to increase facility staffing (both nursing staff and other staffing categories) as well as to improve wages and benefits. Other workgroup representatives have failed to acknowledge that AB 1629's payment methodology has had a positive impact on facility staffing levels across the state. The LDOA provides an incentive for facility's to spend more on staffing and wages by tying the LDOA to the labor costs as part of the calculation of a facility's Medi-Cal reimbursement rate. Please refer to the provider comments related to this issue on page 72.

***ii. Repeal the labor-driven operating allocation established at Welfare & Institutions Code §14126.023(c)(3). (C/A)***

- The savings from the repeal of the labor-driven operating allocation should be used to pay for an increase in the minimum staffing requirements; and,
- The Legislature should use savings from the repeal of the labor-driven operating allocation to prevent cuts to community-based long-term care services.

**General Vote Record**

Yea: 6

Nay: 6

Abstention: 6

**Individual Vote Record**

6 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

6 Abstentions

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

## **Supporting Information from Submitting Organization(s) – C/A**

In today's budget climate, it is more important than ever that Medi-Cal funds be used to the best advantage of consumers who need long term care. California cannot afford to pay profits or bonuses to nursing homes, especially while other Medi-Cal providers serving the same population have taken or will be taking large cuts.

Through FY 07-08, Medi-Cal paid skilled nursing facility operators about \$.5 billion through the labor-driven operating allocation.<sup>xxxii</sup> Additionally, Medi-Cal projects that the labor-driven operating allocation will cost it about \$180 million during FY 08-09.<sup>xxxii</sup> There is no evidence that this spending has improved care or staffing. Nursing home operators can use these taxpayer dollars for any purpose, with no oversight, limitations or accountability.

Public funds should be spent for a public benefit - care for nursing home residents. The savings from the repeal of the labor-driven operating allocation should be used to pay for an increase in the minimum staffing requirements, as proposed in Section B of these recommendations.

Due to the current California budget crisis, the Legislature is considering cuts to core safety net services, including cuts to services that enable persons needing long-term care to remain in the community. If necessary to prevent cuts to community-based long-term care services, the Legislature should use some or all of the savings from the repeal of the labor-driven operating allocation.

### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The specific recommendations seek to eliminate, modify, or divert the labor driven operating allocation rate component (LDOA), which indicates a lack of a basic understanding of the AB 1629 reimbursement methodology by other workgroup representatives. The LDOA is an integral component within the AB 1629 labor cost component and was designed as an incentive to encourage providers to increase facility staffing (both nursing staff and other staffing categories) as well as to improve wages and benefits. Other workgroup representatives have failed to acknowledge that AB 1629's payment methodology has had a positive impact on facility staffing levels across the state. The LDOA provides an incentive for facility's to spend more on staffing and wages by tying the LDOA to the labor costs as part of the calculation of a facility's Medi-Cal reimbursement rate. Please refer to the provider comments related to this issue on page 72.

- iii. *The labor-driven operating allocation should be modified to increase incentives for better staffing; a part of the labor-driven operating allocation should be contingent on the facility meeting the state’s minimum staffing requirements in the base year. Another part would rise in relation to the facility’s staffing – the higher the average hppd level, the higher the labor-driven operating allocation. (SEIU)*

**General Vote Record**

Yea: 6

Nay: 11

Abstention: 1

**Individual Vote Record**

6 Yeas

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

11 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP

1 Abstention

1 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)

### **Supporting Information from Submitting Organization(s) - SEIU**

The labor-driven operating allocation (LDOA) should be modified to increase incentives for better staffing. A part of the LDOA should be contingent on the facility meeting the state's minimum staffing requirements in the base year. Another part would rise in relation to the facility's staffing – the higher the average hppd level, the higher the LDOA. In order to redesign the LDOA appropriately, the state should work with stakeholders to analyze empirical data regarding the extent to which the existing LDOA is linked to better staffing and quality.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

There is no evidence that the LDOA has helped improved staffing or care. The LDOA should be repealed and the savings should be used to cover the cost of increasing the minimum staffing requirements and/or be used to prevent proposed cuts to home and community based services.

#### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The specific recommendations seek to eliminate, modify, or divert the labor driven operating allocation rate component (LDOA), which indicates a lack of a basic understanding of the AB 1629 reimbursement methodology by other workgroup representatives. The LDOA is an integral component within the AB 1629 labor cost component and was designed as an incentive to encourage providers to increase facility staffing (both nursing staff and other staffing categories) as well as to improve wages and benefits. Other workgroup representatives have failed to acknowledge that AB 1629's payment methodology has had a positive impact on facility staffing levels across the state. The LDOA provides an incentive for facility's to spend more on staffing and wages by tying the LDOA to the labor costs as part of the calculation of a facility's Medi-Cal reimbursement rate. Please refer to the provider comments related to this issue on page 72.

## 8. Issue Area: Liability Insurance Pass-Through

### General Vote Record

Yea: 12

Nay: 6

Abstention: 0

### Individual Vote Record

12 Yeas

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

#### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

### Key Stakeholder Perspectives

Numerous recommendations were submitted addressing the Liability Insurance Pass-Through. Stakeholder perspectives varied from maintaining, modifying, to repealing the pass-through.

- Members of the Consumers/Advocates stakeholder group recommend repealing direct pass-through payment of liability insurance costs and imposing reasonable cost controls on liability insurance.

- SEIU recommends reimbursing liability insurance costs as an administrative cost in the administrative cost center, where it would be subject to the 50th percentile cap; at a minimum, SEIU recommends the state place caps on the liability insurance pass-through to address the issue of outliers.
- Providers support the liability insurance as a pass-through cost. They believe it is working as intended, to modify it could result in the unintended consequence of forcing providers to “go bare” (without insurance) which would be detrimental, and that liability insurance is an essential business cost for nursing homes and needs to be reasonably reimbursed.

## **Comments**

### ***Providers***

The workgroup’s provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The specific recommendations seek to broadly modify the Liability Insurance Pass-Through cost component on the basis of a few isolated issues, including incidence of outlier rate component calculations that are clearly extreme and outside the norm. In addition, there is a lack of a basic understanding by other workgroup representatives of the rationale basis for pass-through cost and why the cost of liability was included within the Pass-Through cost component category. Including liability insurance as a pass-through cost is working as intended and to modify it could result in the unintended consequence of forcing providers to “go bare” (without insurance) which would be detrimental. More specifically, the majority of the recommendations go to the issue of the reporting of liability insurance, the cost, and determining whether the reported cost is reasonable. The reporting of liability insurance cost has been a requirement in AB 1629 Supplemental Cost Reports and will likely be incorporated within the cost report re-design process. Additionally, the State Medicaid Plan approved by CMS for the AB 1629 rate methodology, requires that the amount of the Liability Insurance Pass-through cost component be determined under specific Medicare rules related to reasonableness and the allowability of liability costs. DHCS audit staff have aggressively reviewed liability costs as part of their audit process both prior to, and continuing with AB 1629’s implementation. Although the provider community has at times disagreed with the DHCS audit findings and their approach, including contesting findings through DHCS administrative tribunals, the fact is that liability costs are being reviewed. Lastly, liability insurance is an essential business cost for nursing homes and needs to be reasonably reimbursed. None of the recommendations related to the Liability Pass-through cost component meet the fundamental charge to further improve and continue to ensure the quality of resident care.

### ***SEIU***

SEIU recognizes the need for reform in the way liability insurance coverage is handled in the reimbursement system. We look forward to working on ways to adjust the reimbursement mechanism to provide the right incentives and priorities where liability coverage is concerned. At a minimum the state should place caps on the liability insurance pass-through to address the issue of outliers.

## **Recommendations**

### ***i. Adjust the reimbursement methodology and reporting requirements for liability insurance. (CCS)***

- Every facility will be required to present proof annually of liability insurance; costs of liability insurance policies from a carrier should be reimbursed as a 100% pass-through cost, as at present; self-insurance plans, should be reimbursed by the state at 75%, and be presented to the state and comply with certain standards of adequacy set by the state.

## **General Vote Record**

Yea: 0

Nay: 18

Abstention: 0

## **Individual Vote Record**

18 Nays

### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

## **Supporting Information from Submitting Organization(s) - CCS**

The current rate methodology allows for liability insurance costs to be passed through to the state as a full cost reimbursement item. This covers both the cost of purchased insurance and the cost

of self-insurance. Since the implementation of AB 1629 we believe some facilities may have taken advantage of this provision even though overall liability costs appear to be leveling off or declining. We are advised that the lower costs result from lower rates and more competition in the insurance industry. We believe strongly that every facility should be insured to compensate for accidents, medical errors and the like. However, we believe that facilities should be discouraged from exploiting the pass-through of costs for insurance.

Because spending for liability insurance cuts into funds available for patient care under the system of overall caps, we believe quality care can be better financed if liability insurance costs are held down. Therefore we recommend the following:

- Every facility, as part of its licensure, should be required to present proof annually of liability insurance. No facility should be allowed to go bare.
- Costs of liability insurance policies from a carrier should be reimbursed as a 100% pass-through cost as at present.
- Self-insurance plans should be presented to the state and comply with certain standards of adequacy set by the state.
- The cost of self-insurance should be reimbursed by the state at 75%.

This recommendation could save the state some money if facilities continue to self insure or switch to self insurance. There would be some additional state administrative costs to set self-insurance standards and to receive and review insurance information. The impact of this proposal would be measured by monitoring the facility response to this change. The Department of Health Care Services should report on costs and types of liability insurance annually for each facility. The recommendation could be easily implemented and should be implemented by January 2012 as with other proposed recommendations.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

We oppose this recommendation because it would continue reimbursing liability insurance as a 100% pass-through cost.

#### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The specific recommendations seek to broadly modify the Liability Insurance Pass-Through cost component on the basis of a few isolated issues, including incidence of outlier rate component calculations that are clearly extreme and outside the norm. In addition, there is a lack of a basic understanding by other workgroup representatives of the rationale basis for pass-through cost and why the cost of liability was included within the Pass-Through cost component category. Please refer to provider comments found on page 81.

***ii. Repeal direct pass-through payment of liability insurance costs and impose reasonable cost controls on liability insurance. (C/A)***

- Liability insurance payments should be reimbursed as an administrative cost subject to administrative cost caps. Additionally, reimbursement of liability insurance should be restricted to the median cost within the facility's peer group.

**General Vote Record**

Yea: 6

Nay: 6

Abstention: 6

**Individual Vote Record**

6 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

6 Abstentions

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

## **Supporting Information from Submitting Organization(s) – C/A**

Liability insurance payments should be reimbursed as an administrative cost subject to administrative cost caps. Additionally, reimbursement of liability insurance should be restricted to the median cost within the facility's peer group.

Medi-Cal projects that it will spend about \$60 million in FY 08-09 to reimburse freestanding skilled nursing facilities for liability insurance,<sup>xxxiii</sup> plus an unknown additional amount for freestanding subacute SNFs.

Nursing home operators should be required to maintain adequate levels of liability insurance and to provide proof of such insurance to DPH. Medi-Cal should reimburse operators for liability insurance costs within reasonable limits. However, due to inadequate controls, the current system allows substandard nursing home operators to immunize themselves from liability for abuse and neglect by charging Medi-Cal for excessively expensive liability insurance.

Medi-Cal payments to the Western Convalescent Hospital in Los Angeles illustrate this problem. In FY 07-08, its Medi-Cal rate increased by more than a third, from \$121.49 to \$178.27, almost entirely to cover an enormous increase in liability insurance costs.<sup>xxxiv</sup> Its liability insurance per diem increased from \$1.80 in FY 06-07 to \$56.45 in FY 07-08. Based on Western Convalescent's reported Medi-Cal days, Medi-Cal paid it nearly \$1.5 million for liability insurance during FY 07-08, which is about the total amount of citation penalties DPH collects annually from California's 1200 +skilled nursing facilities.

Placing reasonable caps on liability insurance creates an incentive to improve care and allows savings to be spent on improved staffing.

## **Comments**

### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The specific recommendations seek to broadly modify the Liability Insurance Pass-Through cost component on the basis of a few isolated issues, including incidence of outlier rate component calculations that are clearly extreme and outside the norm. In addition, there is a lack of a basic understanding by other workgroup representatives of the rationale basis for pass-through cost and why the cost of liability was included within the Pass-Through cost component category. Please refer to provider comments found on page 81.

- iii. *Reimburse liability insurance costs as an administrative cost in the administrative cost center, where it would be subject to the 50th percentile cap. (SEIU)*

**General Vote Record**

Yea: 11

Nay: 6

Abstention: 1

**Individual Vote Record**

11 Yeas

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

1 Abstention

1 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)

**Supporting Information from Submitting Organization(s) - SEIU**

The liability insurance pass-through for SNFs cost the Medi-Cal program about \$60 million in rate year 2008-09. Rather than continuing as a direct pass-through, there should be reasonable cost controls on facility reimbursement for insurance costs so as to incentivize better care and working conditions that would lower liability insurance claims and costs. One way to accomplish better cost controls would be to reimburse liability insurance costs as an administrative cost in the administrative cost center, where it would be subject to the 50th percentile cap.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

The Legislature should also adopt the additional recommendations the consumer workgroup members made on this issue.

#### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The specific recommendations seek to broadly modify the Liability Insurance Pass-Through cost component on the basis of a few isolated issues, including incidence of outlier rate component calculations that are clearly extreme and outside the norm. In addition, there is a lack of a basic understanding by other workgroup representatives of the rationale basis for pass-through cost and why the cost of liability was included within the Pass-Through cost component category. Please refer to provider comments found on page 81.

## 9. Issue Area: Staff Turnover/Retention

### General Vote Record

Yea: 13

Nay: 4

Abstention: 1

### Individual Vote Record

13 Yeas

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### 1 Skilled Nursing Facilities

- Jocelyn Montgomery, California Association of Health Facilities (CAHF)

4 Nays

#### 4 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)

1 Abstention

#### 1 Skilled Nursing Facilities

- Michael Torgan, Country Villa Health Services

## **Key Stakeholder Perspectives**

Staff turnover and retention emerged as a central issue in the pay-for-performance (P4P) discussion as several P4P recommendations were submitted in this area, despite an earlier workgroup decision to table P4P.

- SEIU recommends the state categorize facilities according to turnover and retention and work with low-performing homes – those with the highest turnover and least stability among staff – on a management audit that identifies the causes of turnover and makes recommendations for improving conditions so as to decrease turnover. Homes that fail to comply with the recommendations should be penalized. High-performing homes should get a small bonus in their Medi-Cal rate.
- Providers support the concept of “pay for performance” but believe it needs to be done in a carefully crafted manner designed to effectively impact all the key elements of quality of care in nursing homes. They further indicate that the OSHPD data shows staff turnover and retention are improving in California nursing homes.
- Members of the Consumers/Advocates stakeholder group recommend providing a financial incentive in the rate system to reduce turnover and improve retention of nursing staff – in a budget neutral manner, the rate system should be adjusted to reward facilities with caregiver turnover rates below the median and caregiver retention rates above the median, while reducing payments to facilities that do not achieve these results.

## **Comments**

### ***Providers***

The workgroup’s provider representatives could not support any of the specific recommendations as they include incentives based on “pay for performance.” Although provider workgroup members initially recommended that this area be explored, the workgroup made a deliberate decision not to consider this recommendation during the workgroup process. In general, OSHPD data shows that staff turnover and retention are improving in California nursing homes. We believe that the financial stability and resources that are provided through AB 1629 are part of the reason that this trend is moving in the right direction. Although we support the concept of “pay for performance” we believe it needs to be done in a carefully crafted manner designed to effectively impact all the key elements of quality of care in nursing homes. We do not believe that implementing financial incentives and punishments in isolation, rather than as part of a comprehensive program, will be effective and that it may actually have the unintended consequence of negatively impacting care in facilities that are penalized.

### ***SEIU***

It is unfortunate that we could not agree on a recommendation in this area, but we hope the department convenes stakeholder meetings so we can work together to make strides to address this important issue. Staff turnover rates are still far too high, and at a minimum the state should

develop a program to evaluate turnover and retention issues in nursing home staff and work with low-performing facilities.

## **Recommendations**

- i. Provide a financial incentive in the rate system to reduce turnover and improve retention of nursing staff. (C/A)*

### **General Vote Record**

Yea: 6

Nay: 6

Abstention: 6

### **Individual Vote Record**

6 Yeas

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

#### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

6 Abstentions

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

### **Supporting Information from Submitting Organization(s) – C/A**

Thus far the AB 1629 rate system has had little impact in decreasing the high turnover rates for nursing staff, which is a leading cause of poor care. According to OSHPD data, nursing assistant

turnover declined slightly from 58.57 percent in 2004 to 54.63 percent in 2007.<sup>xxxv</sup> Turnover rates for licensed nurses declined from 57.98 percent in 2004 to 53.84 in 2007.<sup>xxxvi</sup>

According to OSHPD data presented by DPH in its AB 1629 impact report, retention rates for licensed nurses and CNAs showed improvement both before and after AB 1629 was implemented.<sup>xxxvii</sup> However, a small percentage of facilities have dangerously low retention rates.

In a budget neutral manner, the rate system should be adjusted to reward facilities with caregiver turnover rates below the median and caregiver retention rates above the median, while reducing payments to facilities that do not achieve these results. Tying rates to these factors will give operators an incentive to reduce staff turnover and improve staff retention in their facilities.

## **Comments**

### ***Providers***

The workgroup's provider representatives could not support any of the specific recommendations as they include incentives based on "pay for performance." Please refer to provider comments found on page 89.

*ii. The state should develop a program to evaluate turnover and retention issues in nursing home staff. Specifically, the state should categorize facilities according to turnover and retention and work with low-performing homes – those with the highest turnover and least stability among staff – on a management audit that identifies the causes of turnover and makes recommendations for improving conditions so as to decrease turnover. Homes that fail to comply with the recommendations should be penalized. High-performing homes should get a small bonus in their Medi-Cal rate. (SEIU)*

### **General Vote Record**

Yea: 12

Nay: 1

Abstention: 5

### **Individual Vote Record**

12 Years

#### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

1 Nay

#### **1 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California

5 Abstentions

#### **5 Skilled Nursing Facilities**

- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)

- Michael Torgan, Country Villa Health Services

### **Supporting Information from Submitting Organization(s) – SEIU**

The state should develop a program to evaluate turnover and retention issues in nursing home staff. Specifically, the state should categorize facilities according to turnover and retention and work with low-performing homes – those with the highest turnover and least stability among staff – on a management audit that identifies the causes of turnover and makes recommendations for improving conditions so as to decrease turnover. Homes that fail to comply with the recommendations should be penalized. High-performing homes should get a small bonus in their Medi-Cal rate.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

Although we support this concept, we want more information about who would be conducting and paying for the proposed management audits.

#### ***Providers***

The workgroup’s provider representatives could not support any of the specific recommendations as they include incentives based on “pay for performance.” Please refer to provider comments found on page 89.

#### ***Aging Services of California***

Aging Services of California voted nay on this recommendation because the recommendation was compounded, including some elements our organization agreed with and some we did not.

## 10. Issue Area: Audit System/Process

### General Vote Record

Yea: 16

Nay: 0

Abstention: 2

### Individual Vote Record

16 Yeas

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

#### 4 Skilled Nursing Facilities

- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services
- Lori Costa, Aging Services of California

2 Abstentions

#### 2 Skilled Nursing Facilities

- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)

### Key Stakeholder Perspectives

Most workgroup members supported addressing the audit system/process. Regarding specific recommendations however, members were split predominantly by stakeholder group, with a few notable areas of overlap: requiring nursing home chains to be audited as a group, and establishing clear definitions and providing clarification on problematic terminology.

- Providers recommend considering establishing a combined rate review process and audit appeal process to improve efficiency within the AB 1629 audit and rate setting process, and to reduce the number of audit appeals resulting in reduced State and provider costs.
- Members of the Consumers/Advocates stakeholder group recommend numerous reforms of the audit system. These areas address: home office audits to review corporate office expenses; auditing nursing home chains as a group; frequency of audits; reporting audit impact and findings on the Medi-Cal's AB 1629 webpage; establishing clear definitions and providing clarification on problematic terminology; and, requiring that rate adjustments based on audit appeals be paid within the overall cap.
- SEIU supports reform of the audit system with increased transparency and accountability; they support capping management fees to parent corporations as well as salaries to owners and families.

## **Comments**

### ***Providers***

The workgroup's provider representatives support the audit process, however, could not agree to support some of the specific recommendations because they were duplicative of systems or process currently operative within DHCS or would result in additional costs. For example, recommendations 1 and 2 are specific to home office audit funding and process, which DHCS has already implemented. Implementing recommendations 3 and 4 would require additional costs without any evidence to support their relevance in promoting quality of care. Recommendation 5 to establish clear definitions and provide clarification on problematic terminology, and 7 to consider a combined rate review and audit appeal process, (Provider recommendations), are supported and more thoroughly discussed in depth in the Provider Recommendations document. Implementing both of these recommendations could result in potential DHCS and provider cost savings and efficiencies.

### ***SEIU***

Almost everyone in the workgroup agrees that some reform of the audit system is a good idea. SEIU believes that the reimbursements generally and the ratesetting system in particular must be more accountable. Transparency is a good tool for achieving that goal. Although the vote counts varied, several recommendations received at least a majority vote and we look forward to working toward their implementation.

On a separate but related note, we believe that capping management fees to parent corporations as well as salaries to owners and families is an important part of the overall goals of accountability and transparency. Operators should not be hiding payments by essentially compensating themselves through related entities or people.

We also support placing additional information on the Department's website so that this information is easily accessible. This should include more detailed appeal, deficiency, and citation information on a facility specific basis.

## **Recommendations**

*i. Require and fund home office audits to review corporate office expenses. (C/A)*

### **General Vote Record**

Yea: 12

Nay: 0

Abstention: 6

### **Individual Vote Record**

12 Yeas

#### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Abstentions

#### **6 Skilled Nursing Facilities**

- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services
- Lori Costa, Aging Services of California

## **Supporting Information from Submitting Organization(s) – C/A**

The Audits and Investigation Division reports that AB 1629 did not allocate additional resources to provide for the additional review that is necessary of corporate office expenses.<sup>xxxviii</sup> This oversight should be corrected.

## **Comments**

### ***Providers***

The workgroup's provider representatives support the audit process, however, could not agree to support some of the specific recommendations because they were duplicative of systems or process currently operative within DHCS or would result in additional costs. Please refer to the provider comments found on page 96.

*ii. Require nursing home chains to be audited as a group. (C/A)*

**General Vote Record**

Yea: 17

Nay: 0

Abstention: 1

**Individual Vote Record**

17 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

5 Skilled Nursing Facilities

- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

1 Abstention

1 Skilled Nursing Facilities

- Lori Costa, Aging Services of California

**Supporting Information from Submitting Organization(s) – C/A**

Nursing home chains should be audited as a group to enable auditors to identify and respond more effectively and efficiently to inappropriate or illegal corporate reporting practices.

Some California nursing home chains have a history of financially exploiting the Medi-Cal program through fraud. The most recent example is a December 2008 felony complaint against Centurion Healthcare, the home office for six Sacramento area nursing homes owned by John

Lund. Mr. Lund faces 18 felony counts involving false cost reports, perjury and a scheme to defraud Medi-Cal.<sup>xxxi</sup> The Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) brought these charges after its investigation found that Mr. Lund repeatedly claimed personal expenses in cost reports submitted to Medi-Cal. According to a 40-page declaration by BMFEA, these personal expenses included family vacations in Hawaii and Colorado, season tickets to the Sacramento Kings, tennis lessons for Lund's minor children and expensive remodeling of his homes.<sup>xl</sup>

Auditing nursing home chains as a group will help detect this type of fraud and is a common-sense approach to strengthening accountability.

## **Comments**

### ***Providers***

The workgroup's provider representatives support the audit process, however, could not agree to support some of the specific recommendations because they were duplicative of systems or process currently operative within DHCS or would result in additional costs. Please refer to the provider comments found on page 96.

### ***Aging Services of California***

Aging Services of California abstained on this recommendation because the recommendation statement lacked clarification with respect to the meaning of "group."

- iii. *Require field audits once every two years and desk audits during intervening years. (C/A)*

**General Vote Record**

Yea: 12

Nay: 0

Abstention: 6

**Individual Vote Record**

12 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Abstentions

6 Skilled Nursing Facilities

- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services
- Lori Costa, Aging Services of California

**Supporting Information from Submitting Organization(s) – C/A**

AB 1629 currently requires facilities to be audited once every three years, and expresses legislative intent for limited scope audits in the years between full scope audits.<sup>xli</sup>

More frequent full-scope and limited-scope audits are desirable and feasible. The Audits and Investigation Division reports that it currently has 494 facilities designated for field audit and

492 for desk audit.<sup>xiii</sup> The statute should be upgraded to reflect the current practice of conducting a full-scope audit every other year, with limited-scope audits during intervening years.

**Comments**

***Providers***

The workgroup's provider representatives support the audit process, however, could not agree to support some of the specific recommendations because they were duplicative of systems or process currently operative within DHCS or would result in additional costs. Please refer to the provider comments found on page 96.

- iv. Require DHCS to establish measures on audit system impact and report them on Medi-Cal's AB 1629 webpage. (C/A)*

**General Vote Record**

Yea: 12

Nay: 3

Abstention: 3

**Individual Vote Record**

12 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

3 Nays

3 Skilled Nursing Facilities

- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

3 Abstentions

3 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)

**Supporting Information from Submitting Organization(s) – C/A**

It is critical that the audit system be able to provide meaningful information to stakeholders and the public on its findings and impact. Audit findings should be used to identify and correct weaknesses in the design of the rate system.

### **Comments**

#### ***Providers***

The workgroup's provider representatives support the audit process, however, could not agree to support some of the specific recommendations because they were duplicative of systems or process currently operative within DHCS or would result in additional costs. Please refer to the provider comments found on page 96.

v. *Establish clear definitions and provide clarification on problematic terminology.*  
(C/A)

**General Vote Record**

Yea: 17

Nay: 0

Abstention: 1

**Individual Vote Record**

17 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

5 Skilled Nursing Facilities

- David Farrell, SNF Management
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services
- Lori Costa, Aging Services of California

1 Abstention

1 Skilled Nursing Facilities

- Jim Gomez, California Association of Health Facilities (CAHF)

**Supporting Information from Submitting Organization(s) – C/A**

The Audits and Investigation Division reports that it is unable to provide meaningful information on audit disallowances or audit adjustments because of "the inherent limitations of using the audit as a medium to convert reported data designed for a flat rate prospective rate methodology into the current rate system."<sup>xliii</sup> It also describes complicated steps auditors must take to

reclassify costs due to this same problem. The cost reports should be designed for the current rate system, not the system replaced by AB 1629.

**Comments**

***Providers***

The workgroup's provider representatives support the audit process, however, could not agree to support some of the specific recommendations because they were duplicative of systems or process currently operative within DHCS or would result in additional costs. Please refer to the provider comments found on page 96.

- vi. *Require that rate adjustments based on audit appeals be paid within the overall cap. (C/A)*

**General Vote Record**

Yea: 6

Nay: 6

Abstention: 6

**Individual Vote Record**

6 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

6 Abstentions

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

**Supporting Information from Submitting Organization(s) – C/A**

The Audits and Investigation Division reports "a large failure of the rate methodology is the inclusion of rate adjustments based on audit appeals being paid outside of the overall cap."<sup>xliv</sup> It reports that unknown consequences to the general fund have occurred due to this shortcoming of the system.

The Legislature should correct this problem.

**Comments**

***Providers***

The workgroup's provider representatives support the audit process, however, could not agree to support some of the specific recommendations because they were duplicative of systems or process currently operative within DHCS or would result in additional costs. Please refer to the provider comments found on page 96.

- vii. *Consider establishing a combined rate review process and audit appeal process.  
(Providers)*

**General Vote Record**

Yea: 6

Nay: 0

Abstention: 12

**Individual Vote Record**

6 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

12 Abstentions

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

**Supporting Information from Submitting Organization(s) – Providers**

**Analysis:** Currently there is no formal rate review process and the results of audit appeals impact AB 1629 rate setting. The current audit appeals process is labor and cost intensive for both providers and DHCS. In light of the current status of national and state economies and impact to State finances and provider fiscal concerns, consideration should be given to whether combining these separate DHCS functions would be more efficient, and could result in DHCS and provider cost savings.

Pros:

- Helps to improve efficiency within the AB 1629 audit and rate setting process.
- Should reduce the number of audit appeals resulting in reduced State and provider costs.
- Costs resulting from new workload requirements relating to implementation of an AB 1629 rate review process can be offset by costs savings resulting from elimination of other department workload requirements (reduction and elimination of audit appeals).

Cons:

- Likely workload increase within the AB 1629 Rate Development Unit since no formal rate review process currently exists.

**Impact:** The impact of this recommendation can be measured internally by DHCS through workload analysis in both the Financial Audits Branch and Medi-Cal AB 1629 Rate Development Unit.

**Costs:** Combining these functions should result in cost savings for DHCS and providers. Further study of this recommendation should allow for a more accurate assessment of potential cost savings for DHCS.

**Feasibility:** The recommendation is of importance to ensuring the overall goals of AB 1629 are met and can be sustained. However, the recommendation deserves further research, study and discussion within the stakeholder workgroup and DHCS management staff of Audits and Investigations, Administrative Appeals, and the Medi-Cal Policy Division.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

More information is needed. The recommendation states that a formal rate review process does not exist, but proposes to consolidate the rate review and audit appeal processes. What purpose would a more formal rate review process serve?

## 11. Issue Area: Management Fees

### General Vote Record

Yea: 12

Nay: 6

Abstention: 0

### Individual Vote Record

12 Yeas

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Nays

#### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

### Key Stakeholder Perspectives

The issue of management fees and related recommendations elicited varying perspectives.

- Members of the Consumers/Advocates stakeholder group recommend capping management fees to parent corporations and salaries of owners and their families.

- SEIU recommends the rate system be modified to provide for greater identification and auditing of home office costs and management fees paid to parent corporations and that reimbursement for management fees be capped to discourage corporations from using management fees to disguise profit-taking.
- Providers indicate that proposed management fees recommendations are duplicative of process and practice already in place within DHCS, as the department requires a review of management fees to related organizations to ensure the elimination of inter-company profit, and the review of owner/administrator reasonable compensation.

## **Comments**

### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The recommendations seek to require reporting and a prescriptive review process for corporate management fees. The recommendations reflect a lack of basic understanding of the current reporting requirements and review process that DHCS performs as part of their audit scope. More specifically, the reporting aspects were outlined previously in the discussion of the recommendation to improve and update the cost report. Additionally, other workgroup representatives lack knowledge about the current audit scope employed by DHCS. This scope currently requires a review of management fees to related organizations to ensure the elimination of inter-company profit, and the review of owner/administrator reasonable compensation. These recommendations are unnecessary as they are duplicative of process and practice already in place within DHCS.

## **Recommendations**

- i. Cap management fees to parent corporations and salaries of owners and their families. (C/A)*

### **General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

### **Individual Vote Record**

12 Yeas

#### **6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### **6 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Nays

#### **6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

### **Supporting Information from Submitting Organization(s) – C/A**

AB 1629 contains no controls to prevent excessive management fees to parent corporations and salaries to owners and their families. The rate system must have controls to prevent operators from using funds for corporate or personal purposes that don't benefit residents.

Medi-Cal audit officials informed the workgroup that AB 1629 failed to allocate additional resources needed to perform home office audits, so audits of corporate offices are limited.<sup>xlv</sup> They state that the 50th percentile cap on the administration cost component is relied upon for cost control.<sup>xlvi</sup> This cap has not prevented rapid growth in Medi-Cal spending on administrative costs.

DHCS reports that skilled nursing facility spending on administration, non-labor costs, pass-through and other costs have increased at a more rapid rate than labor costs since AB 1629 was implemented.<sup>xlvii</sup> OSHPD reports that operating margins and operator returns on assets have also risen steeply since AB 1629 was enacted.<sup>xlviii</sup> These trends raise serious concerns about whether the rate system has adequate controls to ensure that Medi-Cal funds are being used to meet AB 1629's objectives.

## **Comments**

### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The recommendations seek to require reporting and a prescriptive review process for corporate management fees. The recommendations reflect a lack of basic understanding of the current reporting requirements and review process that DHCS performs as part of their audit scope. Please refer to provider comments found on page 112.

- ii. The rate system should be modified to provide for greater identification and auditing of home office costs and management fees paid to parent corporations. Reimbursement for management fees should be capped. (SEIU)*

**General Vote Record**

Yea: 12

Nay: 6

Abstention: 0

**Individual Vote Record**

12 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) - SEIU**

Administrative costs have risen more rapidly than most other costs in recent years. The rate system should be modified to provide for greater identification and auditing of home office costs and management fees paid to parent corporations. Reimbursement for management fees should be capped so as to discourage corporations from using management fees as a way to disguise profit-taking.

## **Comments**

### ***Providers***

The workgroup's provider representatives consistently voted six (6) Nays on this general subject area and all of the specific recommendations. The recommendations seek to require reporting and a prescriptive review process for corporate management fees. The recommendations reflect a lack of basic understanding of the current reporting requirements and review process that DHCS performs as part of their audit scope. Please refer to provider comments found on page 112.

## **12. Issue Area: Develop a system for defining, collecting and reporting data on quality of care and quality of life in skilled nursing facilities**

### **General Vote Record**

Yea: 18

Nay: 0

Abstention: 0

### **Individual Vote Record**

18 Yeas

#### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

#### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)

#### 6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

### **Key Stakeholder Perspectives**

Unanimous support was registered for developing a system for defining, collecting and reporting data on quality of care and quality of life in skilled nursing facilities, but workgroup members were not in agreement regarding the specifics of which data elements or indicators to use for the system.

- SEIU supports developing a system for defining, collecting and reporting data on quality of care and quality of life in skilled nursing facilities; they also support the state

eventually measuring resident, staff, and family satisfaction levels in nursing homes, publicly reporting this information, and assessing measures CMS endorses in this area.

- Providers recommend development of a uniform data collection system and a reliable reimbursement mechanism to obtain nursing home resident, family and staff satisfaction measures and adding satisfaction levels and satisfaction improvement rates as publicly reported measures in California.
- Members of the Consumers/Advocates stakeholder group support developing a system for defining, collecting and reporting data on quality of care and quality of life in skilled nursing facilities. Regarding satisfaction surveys, individual members of the group affirmed their support for a credible information-gathering process in which residents have the maximum opportunity to express themselves.

### *Providers*

The workgroup's provider representatives believe that developing a system to define, collect, and report data on the quality of care and life in skilled nursing facilities is extremely important. Unfortunately, removing the discussion of pay for performance from workgroup consideration and other factors related to a lack of understanding of the importance of resident/family and staff satisfaction, divided the workgroup's position on this important recommendation.

- i. AB 1629 Workgroup should be extended until 2012, operate as an advisory body to the Secretary of Health and Human Services, and generate annual reports addressing quality of care and quality of life issues. (CCS)*

**General Vote Record**

Yea: 0

Nay: 16

Abstention: 2

**Individual Vote Record**

16 Nays

4 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

2 Abstentions

2 Consumers/Advocates

- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

**Supporting Information from Submitting Organization(s) - CCS**

One of the conclusions of the AB 1629 Workgroup proceedings is that there is a lack of data (and lack of agreement on appropriate measures) to monitor quality of care and quality of life in

California's nursing facilities. Despite the significant change in the reimbursement methodology and the resulting increase in support, the state has made little progress in monitoring important indicators of quality. While CMS and other states have moved forward in creating reporting and funding systems that include quality care indicators, California's system continues to use labor spending as a crude but leading measure of quality.

Because of the time and cost of creating a monitoring system we believe we need to establish a process to define such a system and spend several years developing a system before we take the step of tying reimbursements directly to quality indicators.

We recommend that the AB 1629 Workgroup be re-named the Workgroup on Quality Care in Nursing Homes, that it be extended to function until January 2012, and that it operate as an advisory body to the Secretary of Health and Human Services. The workgroup should be staffed by DHHS personnel and meet at least quarterly. It should generate a report of its activities, findings and recommendations to the Legislature by March 1<sup>st</sup> each year and by December 31, 2011. Among the topics to be considered by the workgroup are the topics listed in AB 1183 (Sec.14126.023), including the following:

- Identifying, measuring and reporting nursing home patient satisfaction
- Reporting staff training activities and costs, especially in-service training
- Measuring and reporting staff turnover (vacancy rates, average tenure)
- Expanding access for Medi-Cal patients to more facilities.

Providing costs of meetings and support staff for the workgroup would fall to the state. These costs should be minimal. Having a formalized group to advise the state on quality issues should keep pressure on the state and providers to continue to make quality improvements. Setting reporting deadlines for the work will force some discipline on the workgroup to meet its goals.

This recommendation should be readily implemented.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

The workgroup should not be extended for this purpose because there is no consensus within it on such a system.

#### ***Providers***

The workgroup's provider representatives believe that developing a system to define, collect, and report data on the quality of care and life in skilled nursing facilities is extremely important.

Unfortunately, removing the discussion of pay for performance from workgroup consideration and other factors related to a lack of understanding of the importance of resident/family and staff satisfaction, divided the workgroup's position on this important recommendation. Because of the divergent views and lack of willingness of the other representative groups to focus on this issue, extending the workgroup to consider this issue would not be worthwhile.

*ii. Develop a uniform data collection system and a reliable reimbursement mechanism to obtain nursing home resident, family and staff satisfaction measures. Add satisfaction levels and satisfaction improvement rates as publicly reported measures in California. (Providers)<sup>xlix</sup>*

**General Vote Record**

Yea: 6

Nay: 7

Abstention: 5

**Individual Vote Record**

6 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)

7 Nays

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

2 Skilled Nursing Facility Labor

- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

5 Abstentions

1 Consumers/Advocates

- Deborah Doctor, Disability Rights California

4 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council

## **Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** Currently, the yardsticks used to measure "quality" in nursing homes; staffing levels, quality measures, and certification survey results, are inadequate. Not only are there serious inaccuracies with these measures due to lack of timeliness (e.g. staffing reports from OSCAR are collected annually), and distorted portrayals (e.g. QMs fail to reliably adjust for case mix, identification of deficiencies and their scope and severity are applied inconsistently), these measures also fail to capture critical information about resident, family and staff satisfaction. According to both residents and their family members, Quality of life in a nursing home is as important as quality of care, and research shows that high resident and family satisfaction levels are associated with both of these. Additionally, staff satisfaction levels are strongly correlated with resident and family satisfaction levels, quality measures, employee turn-over rates and state survey results. Satisfaction surveys offer an important barometer for providers looking to improve quality, and for consumers looking for the "person-directed" care environment where resident's choice is honored, and quality of life is an important focus. Satisfaction surveys provide an important vehicle to measure these intangible but critical elements of quality.

**Impact:** Conducting, tabulating, and reporting satisfaction survey data will incur some additional costs; the exact amount unknown at this time, as many providers are already doing surveys, but not *in* uniform manner, and not through a consistent mechanism that allows for public reporting and comparison. The financial impact of the initiation of state-wide satisfaction surveys could be minimized if existing companies that provide this kind of service are utilized on a contract basis by government entities.

**Relevance to AB 1629:** The many intended outcomes of AB 1629; to positively impact the quality of residents care; to ensure that residents have ample opportunities to their preference to return to the community; to decrease staff turnover and increase staff stability can be measured and tracked through satisfaction surveys. The implementation of a reimbursement mechanism and standardized system for the collection and reporting of satisfaction data is completely compatible with intent of AB 1629.

**Feasibility:** Satisfaction surveys in nursing homes are conducted on a state-wide basis in several other states. The implementation of statewide satisfaction surveys in California could be highly effective mechanism for measuring and improving quality in nursing homes, and should be studied to determine the costs and feasibility.

## **Comments**

### ***CANHR and Ombudsman & HICAP Services of Northern California***

California is broke. It doesn't have funds for this purpose. Currently, there is not a reliable system for collecting this information. The value of satisfaction surveys is questionable because some operators are using them to defend substandard care.

***SEIU***

SEIU would like the state to eventually measure resident, staff, and family satisfaction levels in nursing homes and publicly report this information. There is not a consensus on which system or systems merit endorsement and we are concerned that the ones that have received prominent attention are not the best indicators to use. We believe it will be helpful to see what CMS endorses in this area.

**B. Additional Workgroup Recommendations**

**1. Category: Reimbursement/Ratesetting/QAF Methodology<sup>1</sup>**

**Recommendations**

- i. Require operators to increase caregiver wages and benefits annually by at least the percentage of rate increase. (C/A)*

**General Vote Record**

Yea: 6

Nay: 6

Abstention: 6

**Individual Vote Record**

6 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Deborah Doctor, Disability Rights California
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)

6 Abstentions

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

## **Supporting Information from Submitting Organization(s) – C/A**

A major purpose of AB 1629's higher rates is to improve the quality of nursing home staff by paying decent wages and benefits. However, skilled nursing facilities have provided very small wage increases to certified nursing assistants (CNAs), who provide most of the direct care to residents. DPH reports that average CNA wages increased from \$10.64 in FY 03-04 to \$11.92 in FY 07-08, a \$1.28 increase (12 percent) over this four-year period.<sup>li</sup> Adjusted for inflation, CNA wages actually decreased during this same period.<sup>lii</sup>

In contrast, average Medi-Cal daily rates increased from \$118.06 to \$152.48 between FY 03-04 and FY 07-08, a 29 percent increase.

The Legislature should amend the rate system to ensure that caregivers, including CNAs, benefit at least proportionately from the generous Medi-Cal rate increases. This change would require operators to use the money for its intended purpose.

## **Comments**

### ***Providers***

The workgroup's provider representatives clearly support the need to improve the wages and benefits of California's nursing facility workforce but could not specifically support the recommendation to increase caregiver wages and benefits annually by at least the percentage of the rate increase. This specific recommendation is indicative of a lack of a basic understanding by other workgroup members about how the AB 1629 facility-specific rate is determined and how the reimbursement system provides the proper incentives for increasing workforce wages and benefits. First of all, the actual cost base is reflective of costs incurred approximately 2 years in arrears. Secondly, the AB 1629 rate is the sum of all cost components including the labor cost component. The labor cost component includes both direct and indirect care labor and the LDOA. The other cost components are indirect non-labor, administration, fair rental value, and pass-through costs. As indicated, the AB 1629 rate calculation is the sum of all of the cost components, therefore, the proportionate percentage increase in the AB 1629 rate mirrors the increase in costs for all of the individual components, not just labor costs. The AB 1629 reimbursement methodology already provides incentives to increase facility spending in labor (staffing, salaries, wages, and benefits) through a higher weighting (actual cost up to the 90<sup>th</sup> percentile) and the LDOA. The LDOA provides an incentive for facility's to spend more on staffing and wages by tying the LDOA to the labor costs as part of the calculation of a facility's Medi-Cal reimbursement rate. Further, the LDOA gives providers a small margin of funding that enables them to make investments in higher staffing, wages, benefits that was unavailable under the old "flat rate" system. Requiring operators to specifically increase caregiver wages and benefits annually by the percentage of the rate increase is not consistent with how the AB 1629 reimbursement methodology was designed.

### ***SEIU***

It is unfortunate that we could not agree on a recommendation in this area, but we hope the department convenes stakeholder meetings so we can work together to make strides to address

this important issue. Staff turnover rates are still far too high, and at a minimum the state should develop a program to evaluate turnover and retention issues in nursing home staff and work with low-performing facilities.

To clarify our position on some of the specific recommendations, we recognize that there is a shortage of healthcare workers, both licensed and unlicensed, but we do not agree with an approach that only targets additional funding for RNs at facilities above the 90<sup>th</sup> percentile. In most cases these facilities have less Medi-Cal utilization than the average.

Additionally, while we want to ensure that providers increase staff wages and benefits, we are not sure if a blanket approach that ties wage and benefit increases to a facility's overall rate increases will accomplish the goal. For example, a facility's rate may decrease overall due to non-labor components, such as a decrease in liability insurance, yet receive an increase in their direct care labor component. Additionally, rate increases & decreases often vary by a significant amount due to a variety of factors. To demonstrate this point, note that between the 2007-2008 and 2008-2009 rate year, facility rate changes varied from a decrease of 31% to an increase of 43%. We look forward to working with stakeholders to identify potential solutions to guarantee that all staff receive consistent wage and benefit improvements.

*ii. Increase the reimbursement rate to 100% of costs for RN direct care staffing and Gerontological Nurse Practitioner services in nursing homes. (Providers)*

**General Vote Record**

Yea: 6

Nay: 10

Abstention: 2

**Individual Vote Record**

6 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

10 Nays

4 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP

6 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)
- Richard Thomason, SEIU United Healthcare Workers West (SEIU UHW)

2 Abstentions

2 Consumers/Advocates

- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

**Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** Research shows a correlation between increased RN staffing levels and tenure in nursing homes and better resident outcomes. Additionally, the use of GPNs in nursing homes has been correlated with fewer hospitalizations, decreased depression rates, and other positive impacts on resident outcomes. Because there is a shortage of RNs and advanced practices nurses in California, nursing home providers must be able to offer competitive salaries and benefits in order to effectively compete in the California nurse job market. Increasing the rate reimbursement from the current level of 90% of costs to 100% of costs for RNs engaged in direct resident care, and for the care services of a GNP incentivizes providers to employ and retain RNs and GPNs for direct patient care. It also enables them to offer competitive wages, thereby increasing their ability to recruit these nurses to the skilled nursing setting.

**Impact:** Initially this would likely result in increased costs, but very possibly this would be offset in the long term by decreased costs of care (e.g. less pressure ulcers and avoidable hospitalizations). The financial impact of this recommendation can be measured annually through simple analysis of changes in costs reported through OSHPD reporting, provider audits, facility licensing surveys, and the annual rate setting process. Further analysis could be completed by **independent** organizations and/or State agencies, to determine whether or not staffing costs were being offset by lower costs of care as demonstrated by improved in specific Quality Measures and decreased hospitalizations in those settings where RN and GPN hours have increased.

**Relevance to AB 1629:** Revising the rate reimbursement system to encourage and facilitate an increase and stabilization of RNs and GPNs in nursing homes has the potential to increase the quality of resident care and therefore is directly relevant to the intent of AB 1629.

**Feasibility:** A recent survey conducted by the American Health Care Association on the 2007 staffing and turnover rates in nursing facilities documents that a chronic direct-care workforce shortage exists in skilled nursing facilities all over the country. The vacancy rate for staff RNs was particularly high at 16.3% nationally and 11.6% in California. This vacancy rate is a reflection of a general shortage of licensed nurses; a shortage that is projected to worsen in future. We believe that the potential lack of available nurse candidates should not be a deterrent from creating incentives to attract and retain an increased number of RNs in the skilled nursing setting; however it is an important consideration in terms of setting mandatory ratios that fail to adjust to the lack of available nurses to fill positions. This recommendation warrants further study to determine the feasibility of implementation in terms of costs and RN/GPN availability.

## **Comments**

### ***CANHR and Ombudsman & HICAP Services of Northern California***

This proposal would have limited impact because RN wages are already reimbursed at 100%, except for SNFs whose direct labor costs exceed the 90th percentile. RN wages have already increased substantially since AB 1629 took effect, while inflation-adjusted wages for CNAs have decreased. CNA wage concerns should be addressed ahead of this proposal.

- iii. *Prohibit reimbursement of facility legal fees for appeals of citations, deficiencies, inspection and complaint investigation findings, and for participation in residents' transfer and discharge appeals. (C/A)<sup>liii</sup>*

**General Vote Record**

Yea: 11

Nay: 6

Abstention: 0

**Individual Vote Record**

11 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) – C/A**

Medi-Cal should not be funding nursing homes to mount expensive legal challenges to defend substandard care. Yet that is exactly what it is doing through the reimbursement system. Providers bill Medi-Cal for legal fees for appeals and lawsuits challenging citations, deficiencies, enforcement actions and other inspection-related matters.

This proposal would not alter providers' due process rights, but it would remove the public subsidies for these actions. The subsidies encourage litigious behavior that has gridlocked California's nursing home enforcement system. Providers should be required to fund the costs of their appeals, just as consumers are currently required to do.

Estimated savings are unknown. Medi-Cal audit officials told the workgroup Medi-Cal doesn't know how much it spends on facility legal fees because these costs are "buried" in cost reports. This problem should be corrected by amending the cost report to fully disclose legal fees and their purpose in order to detect and deter improper costs.

Audits & Investigations reports that it is using guidelines in CMS Publication 15-1, Sections 2102.1, 2102.2, 2102.3 and 2183 to determine the appropriateness of legal fees.<sup>liv</sup> These guidelines are insufficient because they do not address legal fees related to inspection and investigation findings.

## **Comments**

### ***Providers***

Legal fees for defense of any cause of action are a legitimate cost for any business. The Medi-Cal program shares in these costs proportionate to number of Medi-Cal residents cared for in the facility. Denying the provider a fundamental right to claim these legitimate business costs would be similar to denying an indigent individual access to publicly paid legal representation. Lastly, Medi-Cal audit staff generally reviews legal fees as part of their audit scope. The scope includes a review for reasonableness and Medicare program requirements to be claimed as allowable costs. This review process should be sufficient in determining whether a provider has acted reasonably and is entitled to claim these costs.

- iv. Increase the rate of nursing home administrator salary and benefit costs to the 90th percentile. (Providers)*

**General Vote Record**

Yea: 6

Nay: 11

Abstention: 0

**Individual Vote Record**

6 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

11 Nays

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

**Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** Stable, competent leadership in the skill nursing facilities is of critical importance to quality improvement and sustainability. Studies such as “Beyond Unloving Care” by Susan Eaton (2002) have demonstrated the correlation between effective leadership and staff turnover, and the link between high turnover and quality of resident care. The current turnover rate for nursing home administrators is approximately 40%. This due in part to the extreme stress of being responsible for the day-to-day care and services, financial viability, and regulatory compliance of this complex care setting. Recruiting and keeping competent and experienced

administrators is contingent on being able to offer competitive salaries and benefits in the health care marketplace.

Currently, under AB 1629, the cost for a nursing home administrator's salary is reimbursed at the 50<sup>th</sup> percentile. This has a limiting effect on the ability of facilities offer competitive wages to high performing administrators. Increasing the reimbursement rate from the 50<sup>th</sup> percentile to the 90<sup>th</sup> percentile puts the costs for this critical leadership position in the same reimbursement category as direct care staff and director of nursing.

**Impact:** The initial increased costs of higher salary reimbursement to administrator would, quite possibly, be off-set by a decrease in turn-over, not only of the administrators, but of the direct care staff working for them. The impact of this recommendation can be measured internally by DHCS through workload analysis in both the Financial Audits Branch and Medi-Cal AB 1629 Rate Development Unit, by OSHPD in turnover data, and the DPH, Licensing and Certification in trends in Quality Measures.

**Relevance to AB 1629:** Revising the rate reimbursement system to increase the presence of high performing nursing home administrators in California nursing homes has the potential to increase the quality of resident care and therefore is directly relevant to the intent of AB 1629.

**Feasibility:** This recommendation warrants further study to determine the feasibility of implementation in terms of initial projected costs, and potential cost offsets due to decreased staff turnover.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

The proposal incorrectly states that the cost for a nursing home administrator's salary is reimbursed at the 50th percentile. Although overall administrative costs are capped at the 50th percentile, nursing home administrator salaries are not directly capped at this level. SNF operators can increase reimbursement for administrator salaries by holding down overall administrative costs, or can use other funding sources (e.g., Medicare, private pay) for this purpose. Priority should be given to increasing wages and benefits for certified nursing assistants.

*v. Increase Quality Assurance Fee revenues; the quality assurance fee should be extended to a facility's Medicare revenues. (SEIU)*

**General Vote Record**

Yea: 11

Nay: 6

Abstention: 0

**Individual Vote Record**

11 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) – SEIU**

In order to bring more revenue into the system, the quality assurance fee should be extended to a facility's Medicare revenues. DHCS should also review the associated Multi-Level Retirement Community Quality Assurance Fee Exemption Policy to determine whether the requirement of 40% or less SNF units maximum is still appropriate. At a minimum, the following items shall be considered: estimated annual amount of total additional revenue generated by expanding the QAF by various scenarios, potential impacts of the additional cost on facilities with low Medi-Cal utilization, how best to ensure that QAF revenue is entirely dedicated to long term care

programs (both Medi-Cal and non-Medi-Cal) and not used for any other state general fund purpose, the growth in the number of MLRC exempt facilities from 05/06 to present, the Medi-Cal utilization of the exempted MLRCs and the percent of SNF beds in the MLRC exempt facilities.

We recommend that the new revenue generated by expanding the QAF be dedicated to fund the additional expenses related to the increase in staffing level requirements, Olmstead implementation and/or other initiatives that will be reimbursed through the direct care cost center. If the QAF generates more funding than is necessary, the residual funds should only be used for other long term care programs (HCBS, LTC ombudsman, etc).

Given the extraordinary state budget crisis, it is imperative to consider additional revenue resources in order to implement recommended changes to the Medi-Cal SNF reimbursement system and other skilled nursing related programs that are not budget neutral. The Legislative Analyst Office estimated that \$26 million in new revenue could be generated by expanding the QAF to include Medicare revenue.<sup>lv</sup>

## **Comments**

### ***SEIU***

Workgroup discussions indicate a lack of consensus on this issue. The state should still consider expanding the Quality Assurance Fee in order to implement some of these recommendations, especially improvements to staffing standards. At a minimum the state should review the current methodology for facility exemptions.

### ***Providers***

Workgroup Provider representatives reject the recommendation to expand the Quality Assurance Fee (QAF) to include Medicare revenue, as it would only increase costs to nursing facilities without providing any direct benefit to improving quality.

vi. **Recover Rate Overpayments to SNFs. (SEIU)**

**General Vote Record**

Yea: 11

Nay: 6

Abstention: 0

**Individual Vote Record**

11 Yeas

**6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

**5 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

6 Nays

**6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) - SEIU**

According to DHCS Audits and Investigations, while the department does recover overpayments when services are not actually rendered or when there is an improper share-of-cost deduction, payments to facilities are otherwise not recovered because this would require a reconciliation of what was actually spent with what was in the rate for the various cost categories. Reconciliation is apparently not part of the ratesetting process, but it should be. Overpayments should be recovered.

## **Comments**

### ***SEIU***

We do not know the outcome of the voting on these issues, but we encourage the department to work with stakeholders to discuss a consistent methodology for determining a reimbursement rate for a facility that experienced a change in ownership and make publicly available information related to rate appeals to foster additional transparency.

### ***Providers***

Provider workgroup representatives rejected the recommendation recover provider overpayments to SNF's as it is duplicative of current overpayment recovery requirements included in State regulations and contained by reference within the State Plan for AB 1629 Reimbursement approved by the Centers for Medicare and Medicaid Services (CMS).

- vii. *Ratesetting, following a Change of Ownership (CHOW), should be consistent when a facility has submitted six months of its own data. (SEIU)*

**General Vote Record**

Yea: 16

Nay: 0

Abstention: 1

**Individual Vote Record**

16 Yeas

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

1 Abstention

1 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)

**Supporting Information from Submitting Organization(s) - SEIU**

Facilities that experienced CHOWs in 2006 and have six months of data in 2007 are subject to one of two rate-setting methodologies without an explanation as to why they were subject to one rather than the other: 1) The old owner's rate, inflated per CPI and adjusted for mandates, for 2008/2009; or 2) Weighted average Peer Group Rate.

Ratesetting following a CHOW should be consistent when a facility has submitted six months of its own data. Doing so creates an opportunity to reward providers who take over a troubled SNF and stabilize that SNF with increased wages and staffing; at the same time we should have the opportunity to penalize a provider who takes over a SNF and reduces wages, staffing and any other costs.

### **Comments**

#### ***Providers***

Provider workgroup representatives strongly support this recommendation.

**viii. Condition rate increases on compliance with minimum staffing requirements.  
(C/A)**

- Nursing homes that do not meet minimum staffing requirements on an annualized basis should be disqualified from receiving a Medi-Cal rate increase during the following rate year.

**General Vote Record**

Yea: 6

Nay: 6

Abstention: 5

**Individual Vote Record**

6 Yeas

**6 Consumers/Advocates**

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

6 Nays

**6 Skilled Nursing Facilities**

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

5 Abstentions

**5 Skilled Nursing Facility Labor**

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

**Supporting Information from Submitting Organization(s) – C/A**

According to OSHPD data, 144 California nursing homes averaged less than 3.2 hprd throughout 2006. California should not be rewarding nursing homes that are still failing to comply with minimum staffing standards that were set nine years ago. Nursing homes that do not meet

minimum staffing requirements on an annualized basis should be disqualified from receiving a Medi-Cal rate increase during the following rate year.

### **Comments**

#### ***Providers***

The recommendation to disqualify a facility from receiving reimbursement if they fail to meet the minimum staffing standard was rejected because it unnecessarily penalizes providers and falls within the pay for performance category. As indicated elsewhere in this document, the provider representatives support the concept of “pay for performance” but believe it needs to be done in a carefully crafted manner designed to effectively impact all the key elements of quality of care in nursing homes. Implementing financial incentives and punishments in isolation, rather than as part of a comprehensive program, would not be effective and could actually have the unintended consequence of negatively impacting care in facilities that are penalized.

- ix. *Consider expansion of the pass-through cost component to incentivize further improvement in resident care and worker safety while also encouraging investment in medical information technology. (Providers)*

**General Vote Record**

Yea: 6

Nay: 1

Abstention: 10

**Individual Vote Record**

6 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

1 Nay

1 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)

10 Abstentions

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

**Supporting Information from Submitting Organization(s) – Providers**

**Analysis:** A pass-through cost component was included as an integral aspect of the AB 1629 reimbursement methodology to ensure balance between Medi-Cal reimbursement and specific

provider operating costs, which were outside the provider's scope of influence or control. Pass-through means that no specific limit or cost CAP is established when developing the individual facility-specific rate component, however, facility specific rates in the aggregate remain subject to control under the established annual global budget CAP. Currently, provider operating costs for licensing, property taxes, and liability insurance, are encompassed within the AB 1629 pass-through cost component. In addition, AB 1629 included a pass-through cost component to incentivize provider investment in sustaining and developing formal workforce training programs (A separate recommendation has been made to expand the scope of the Caregiver training pass-through). Expanding the scope of the current AB 1629 pass-through component to include specific costs identified with improving resident quality of care and safety, as well as workforce safety and working conditions, could advance the intended goals established by AB 1629. For example, the investment in medical care information technology such as electronic medical records and e-prescribing, has been strongly encouraged by national and state political leaders. Additionally, the replacement of old resident beds with new electric models, and the acquisition new model resident lift devices and equipment, will benefit both resident care and improve workforce safety and working conditions. National studies have identified that medical information technology, and resident lift equipment, can benefit care and improve safety for residents while ultimately reducing the overall costs of medical care. Expanding the AB 1629 pass-through cost component category to include specified costs such as these would encourage provider investment in these types of costs. Investment by providers in these costs will ultimately contribute to improving resident care and safety, workforce safety and working conditions, and increased efficiencies leading to reduction in overall costs in the future.

**Pros:**

- Significantly contributes to improving resident care and safety.
- Significantly contributes to improving workforce safety and working conditions.
- Improves overall efficiency which may lead to reduction of future operating costs.
- Supports specific medical care policy goals outlined by State and national political leadership.

**Cons:**

- Results in a re-distribution of funding within the current AB 1629 facility-specific cost component structure.

**Impact:** The impact of this recommendation can be measured by tracking whether expenditures are being made; use of specifically identified resident care measures and indicators; monitoring worker safety programs; and close tracking of worker risk, injury, and compensation costs. Employee satisfaction surveys can also be used as a tool to track the impact as well.

**Costs:** Implementing this recommendation is budget neutral as it merely results in a re-distribution of costs within the current AB 1629 facility-specific rate components. There is no increased cost to the State as facility rates in the aggregate remain subject to annual global budget CAPs.

**Feasibility:** The recommendation is of immediate importance to both enhancing and ensuring the overall goals of AB 1629 are met. In light of the current status of national and state

economies and the need to curtail health care costs, there should be no impediments to moving forward with implementing this recommendation.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

More details are needed. Although there is value in new technology, there must be reasonable controls on the type of technology and costs. A general pass-through for this purpose is likely to result in excessive spending that reduces funds for direct care. As for purchases of new beds and lifts, providers should be investing more of their own funds for these costs. When sold, these assets produce substantial return for providers that are not shared with Medi-Cal.

#### ***SEIU***

While SEIU supports improving resident quality of care and safety and workforce safety and working conditions, the provider proposal for a new passthrough is too broad, but we look forward to working with stakeholders to craft a recommendation that is more targeted. We recognize that worker and resident injuries remain far too high in nursing homes and this is an important area that needs to be addressed.

Additionally while we support expanding the utilization of Health IT in nursing homes, we cannot support a pass-through within the Medi-Cal reimbursement system until we know the outcome of the federal stimulus package negotiations. It is possible that several billion dollars of funding will be available for Health IT. We hope the state of California can capture some of those funds for skilled nursing facilities. It is too premature to design a passthrough for Health IT until we know the outcome of various federal initiatives.

*x. The system should build in a rate incentive for facilities to create quality of care committees that bring together workers and managers to address staffing and quality care issues. (SEIU)*

**General Vote Record**

Yea: 10

Nay: 6

Abstention: 1

**Individual Vote Record**

10 Yeas

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

1 Abstention

1 Consumers/Advocates

- Deborah Doctor, Disability Rights California

**Supporting Information from Submitting Organization(s) - SEIU**

Finally, the system should build in a rate incentive for facilities to create quality of care committees that bring together workers and managers to address staffing and quality care issues. Such committees, when facilitated by third party mediation with a mediator familiar with nursing

homes if necessary to resolve disputes, can be a powerful force for improving employee satisfaction and quality care.

### **Comments**

#### ***SEIU***

SEIU believes it is important for labor and management to work cooperatively together to address situations and find solutions to improve the quality of care and quality of life for residents. We have begun the process of creating specific quality care committees in the facilities where we represent workers. Like many other workgroup participants, SEIU is actively involved in the culture change movement. We believe it is important to promote strategies that promote resident-centered care.

#### ***Provider***

The recommendation to create quality of care committees was rejected by the workgroup's provider representatives because this is already required by State and federal regulations. These types of committees may more commonly be referred to or described as "Quality Assurance Committee, Interdisciplinary Team, and Patient Care Committee."

***xi. Increase the percentile cap for direct patient care staff to create an incentive to increase wages and benefits for that staff. (CCS)***

- Create a higher percentile level for direct care (as opposed to indirect care) staff costs at 95% of a facility's peer group spending, with a mechanism to graduate this additional 5% to increases in wages and benefits for direct care staff over a set base year.

**General Vote Record**

Yea: 1

Nay: 11

Abstention: 5

**Individual Vote Record**

1 Yea

1 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)

11 Nays

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

5 Abstentions

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

## **Supporting Information from Submitting Organization(s) – CCS**

The current rate methodology provides for reimbursement of actual spending on direct patient care staff up to the 90<sup>th</sup> percentile of a facility's peer group spending for that purpose. This reflects the belief that quality care is directly related to direct care staffing. Research also shows that, up to a certain level quality care is positively correlated with the length of tenure of the care giving staff...that is, the more experienced the staff the better the care. The current reimbursement system blends funding for staffing levels, staff turnover (tenure) and compensation. Compensation in turn affects retention and turnover. The recommendation to adapt the LDOA to reward staffing levels begins to separate the different aspects of tying quality improvements to labor spending.

We further recommend creating a higher percentile level for direct care (as opposed to indirect care) staff costs at 95% of a facility's peer group spending. We recommend that the state work with the stakeholder workgroup to develop a mechanism to graduate this additional 5% to increases in wages and benefits for direct care staff over a set base year. Under this approach the state funding system would direct significant resources to labor spending but also allow for additional amounts for increased staffing (Subsection A: Issue Area: Labor-Driven Operating Allocation; Recommendation I) and increases in compensation (Subsection B: Category: Reimbursement/Ratesetting/QAF Methodology; Recommendation XI). As a starting point for discussion, we suggest a system in which each additional \$1 of average compensation over a base level triggers an additional 1% percentile increase in the direct care staffing calculation. We recommend that legislation be introduced to allow this change to take effect on January 1, 2011 and be reflected in rates set in August 2012.

This recommendation could cost the state a significant amount of additional funding assuming that facilities take advantage of the provision and the universal cap is sufficient to allow facilities to receive the increase. We support increasing the cap to allow funding for this recommendation (or abolishing the universal cap pending the results of Subsection B: Category: Research, Study, Data Collection and Reporting; Recommendation IV). There would also be minimal costs to the state to develop the funding mechanism and to track the compensation increases over the base year. The impact of the change would be measured by data showing changes in the level of compensation year to year.

This recommendation could be implemented with relative ease.

## **Comments**

### ***CANHR and Ombudsman & HICAP Services of Northern California***

We oppose this recommendation because it calls for increasing overall spending and possibly abolishing the universal cap.

## **General Comments Regarding Reimbursement/Rate Setting/QAF Methodology Category**

### ***Providers***

Workgroup provider representatives agreed with 3 of the 11 specific recommendations including Recommendation IV to increase the rate of nursing home salary and benefit costs to the 90<sup>th</sup> percentile; recommendation VII to review and update the rate after a Change in Ownership; and recommendation ix to consider incentivizing technology and resident care equipment purchases through pass-through cost reimbursement. (Recommendations IV and IX are more thoroughly discussed within the Provider Recommendations document). Provider representatives rejected Recommendation III to prohibit reimbursement for legal fees because legal fees are a necessary cost of operating a nursing facility and the DHCS audit process incorporates a review of legal fees to determine whether they are both necessary and reasonable. Recommendation V to expand the Quality Assurance Fee (QAF) to include Medicare revenue was also rejected as it would only increase costs to nursing facilities without providing any direct benefit to improving quality. Recommendation VI to recover provider overpayments to SNF's was rejected as it is duplicative of current overpayment recovery requirements included in State regulations and contained by reference within the State Plan for AB 1629 Reimbursement approved by the Centers for Medicare and Medicaid Services (CMS). Recommendation viii to disqualify a facility from receiving reimbursement if they failed to meet the minimum staffing standard was rejected because it unnecessarily penalizes providers and falls within the pay for performance category. As indicated elsewhere in this document, the provider representatives support the concept of "pay for performance" but believe it needs to be done in a carefully crafted manner designed to effectively impact all the key elements of quality of care in nursing homes. Implementing financial incentives and punishments in isolation, rather than as part of a comprehensive program, would not be effective and could actually have the unintended consequence of negatively impacting care in facilities that are penalized. Recommendation X to create quality of care committees was rejected because this is already required by State and federal regulations. These types of committees may more commonly be referred to or described as "Quality Assurance Committee, Interdisciplinary Team, and Patient Care Committee". Recommendation XI to increase the percentile CAP for direct care staff to 95% was rejected as it deserves further study.

## 2. Category: State Processes and Procedures

### Recommendations

- i. *Discontinue the process of continuing to extend AB 1629 legislative sunset dates by removing sunset date language and making the AB 1629 reimbursement system permanent. (Providers)*

### General Vote Record

Yea: 6

Nay: 10

Abstention: 1

### Individual Vote Record

6 Yeas

#### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

10 Nays

#### 5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California

#### 5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

1 Abstention

#### 1 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)

## **Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** Concern over sustainability and permanency is impeding progress for providers in making budgetary decisions that can positively impact the overall goals established by AB 1629 to improve the quality of care in California’s skilled nursing facilities. Skilled nursing providers understand the need to invest in their workforce and other aspects of care that contribute to improving quality. This understanding and commitment is validated by the fact that these providers contribute approximately \$280 million to the State annually as their commitment to sustaining the AB 1629 reimbursement methodology. Providers remain skeptical and reluctant to invest without some assurance that the current methodology will be sustained in the future, remains within the original conceptual policy parameters and design, and won’t be subject to unreasonable changes. More recently, up to date OSHPD skilled nursing facility financial data and reports prepared by CDPH, are indicative that the AB 1629 reimbursement methodology is making progress in meeting legislative intent. The reimbursement system prior to AB 1629 was a flat-rate median system that required providers to control costs instead of investing in quality. The conceptual outline for the AB 1629 rate components and rate calculation process were purposefully designed to meet specific policy parameters that would contribute to AB 1629’s legislative intent. The continuous process of legislating periodic extensions of sunset dates for the AB 1629 reimbursement methodology, gives no assurance to providers that increased investment will be sustained for the future. Providers remain concerned that the AB 1629 reimbursement methodology could end, be significantly modified, or could revert back to the prior flat-rate system. Should any of these factors occur, providers would face significantly higher operating costs with shortfalls in Medi-Cal reimbursement. Making the AB 1629 reimbursement methodology permanent does not obviate the need, or take away, the opportunity for stakeholders to periodically monitor and review the effectiveness of the AB 1629 reimbursement model.

### Pros:

- Mitigates provider impediments to advancing costs for increased staffing, improving workforce wages and benefits, and improving facility infrastructure by providing some assurance that the base structure of the AB 1629 reimbursement methodology will remain in place.
- Consistent with analysis of recent reports identifying provider concerns and impediments to making investments that impact the effectiveness of AB 1629 in meeting established intent.
- Supports the premise that policy makers, consumer advocates, organized labor, and providers are truly committed to a reimbursement method that promotes quality.

### Cons:

- None

**Impact:** The impact of this recommendation can be measured annually through simple analysis of changes in costs reported through OSHPD reporting, provider audits, facility licensing surveys, and the annual rate setting process. Further, periodic reviews by independent organizations, State agencies, and stakeholder workgroups, can also facilitate and augment ongoing analysis and measurement of whether AB 1629 is meeting legislative intent.

**Costs:** As indicated, implementing this recommendation is budget neutral.

**Feasibility:** This is a recommendation of immediate importance to ensuring the overall goals of AB 1629 are met and can be sustained. Given the budget neutral aspects of the recommendation, there are no true impediments to implementing this recommendation that we are aware of.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

The rate system needs to be reformed, not institutionalized.

#### ***SEIU***

SEIU supports retaining a facility-specific reimbursement system that incentivizes improvements in quality resident care, decent wages & benefits for staff, with more transparency and accountability, and are open to supporting longer extensions of the sunset date rather than just 1 or 2 years at a time. The current reimbursement system is not perfect and there are numerous concerns of its impact and outcomes, as demonstrated by the existence of this workgroup. Key changes should be implemented and further evaluation conducted before the sunset date language is entirely eliminated.

*ii. Have appeal information publicly available on the AB1629 website. (SEIU)*

**General Vote Record**

Yea: 11

Nay: 6

Abstention: 0

**Individual Vote Record**

11 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) - SEIU**

Facilities appeal rates and some are successful in modifying their rates long after their initial rate was published. It is a necessity to have appeal information publicly available on the AB1629 website, including the following specific data:

- Name of facilities statewide that filed appeals;
- Result of the appeal;
- Specific information related to appeal, such as:
  1. Cost Center category or categories involved in the appeal;

2. Additional monies received by the facility for each cost center and the date received; and
3. In each Cost Center category where an appeal was granted, the specific reason for granting the appeal.

### **Comments**

#### ***Providers***

Workgroup provider representatives rejected the recommendation to publicly report appeal information on the web, as it was vague and unclear as to what information is in question and should be publicly reported.

iii. *Clarify cost categorization and related definitions through adoption of regulations. (Providers)*

**General Vote Record**

Yea: 9

Nay: 0

Abstention: 8

**Individual Vote Record**

9 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

1 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)

2 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)

8 Abstentions

5 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California

3 Skilled Nursing Facility Labor

- Dionne Jimenez, SEIU International
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

**Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** Currently the law, State Plan, and a limited number of Medi-Cal Provider bulletins have been utilized to guide provider supplemental reporting, the audit, and rate setting process. The use of the provider bulletin mechanism to establish and clarify policy has been useful for

implementing new programs as it allows DHCS to implement new programs and Medi-Cal policy changes on an expeditious basis. However, it lacks the mechanism required of public input through a regulatory process. The lack of clear policy related to some aspects of AB 1629's reimbursement methodology has resulted in disagreements between audit staff and providers. These disagreements lead to audit appeals and rate calculation errors that could have been avoided had policy been clear. For example, an issue related to the miscategorization of contract staff providing support services within a nursing facility, lead to multiple audit appeals and ultimately required DHCS to amend rates for a large number of providers. The issue could have been avoided if policy guidance had been clarified within regulation or other provider instruction. Given that AB 1629 reimbursement methodology has been implemented and in place for more than 3 years, it is time for DHCS to move forward with the development of regulations in advance of the requirement that they be in place by July 31, 2010 (Welfare and Institutions Code 14126.027 (c)).

**Pros:**

- Helps to clarify requirements applicable to all stakeholders including DHCS, providers, and others.
- Helps to improve the accuracy in cost reporting and rate calculation by mitigating questions and misinterpretation related to issues such as cost categorization.
- Reduces the number of audit and rate calculation appeals.

**Cons:**

- Requires DHCS to develop and promulgate regulations through a formal rulemaking process.

**Impact:** The impact of this recommendation can be measured internally by DHCS through workload analysis in both the Financial Audits Branch and Medi-Cal AB 1629 Rate Development Unit. After regulations are promulgated, the analysis should focus on whether the numbers of AB 1629 audit and rate calculation appeals have been reduced from levels prior to the time in which the regulations become effective.

**Costs:** The cost to develop and implement regulations is an internal staffing cost to the responsible State department, in this case, DHCS.

**Feasibility:** The recommendation is of immediate importance to ensuring the overall goals of AB 1629 are met and can be sustained. Additionally, implementing the regulation is supported in current law. Given that costs are internal to DHCS and there is no new general fund requirement, there should be no true impediment to implementing this recommendation with the exception of internal workload priorities within DHCS.

## **Comments**

### ***SEIU***

If the state decides to move forward with developing regulations prior to the July 31, 2010 deadline, the state should do so in consultation with stakeholders to determine which areas of the reimbursement methodology will be clarified. SEIU would like more information from the stakeholders and the state on which areas are of greatest concern.

## **General Comments Regarding State Processes and Procedures Category**

### ***Providers***

Workgroup provider representatives supported 2 of the 3 recommendations including recommendation 1 to discontinue the sunset process and make AB 1629 permanent, and recommendation 3 to clarify cost categorization and related definitions through adopting regulations. Both of these recommendations were made as initial provider recommendations and are more thoroughly discussed in the Provider Recommendations Document. Making AB 1629 permanent is a critically important recommendation which could significantly advance AB 1629's progress in achieving overall goals. Implementing this recommendation would help to remove impediments such as provider skepticism and fear that AB 1629 will be repealed at some point in the future, leaving providers with significantly higher costs and inadequate Medi-Cal reimbursement. Workgroup provider representatives rejected recommendation 2 to publicly report appeal information on the web as it was vague and unclear as to what information is in question and should be publicly reported.

### 3. Category: Research, Study, Data Collection and Reporting

#### Recommendations

- i. Review impact of current cost component caps in meeting AB 1629 goals in improving resident quality of care. (Providers)*

#### General Vote Record

Yea: 6

Nay: 2

Abstention: 9

#### Individual Vote Record

6 Yeas

##### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

2 Nays

##### 1 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California

##### 1 Skilled Nursing Facility Labor

- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)

9 Abstentions

##### 5 Consumers/Advocates

- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

##### 4 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

## **Supporting Information from Submitting Organization(s) – Providers**

**Analysis:** AB 1629 cost caps were developed based on factors designed to both incentivize spending in certain categories such as labor, while also controlling costs of a general nature such as administration. Given that AB 1629 has been in place for more than 3 years, it is time for DHCS and stakeholders to review the impact and effectiveness of the current cost component CAPS in meeting AB 1629 goals. Review and analysis of the current cost component CAPS should be completed to determine whether the CAPs are meeting the stated intent. Consideration then can be given to whether CAPS should be adjusted either up or down, or removed altogether. Further, additional analysis should be completed to determine whether certain costs should remain within specified rate components subject to CAPs or shifted to other cost component categories. (Given available information and justification, recommendations to shift some specific costs to other categories, or to specifically adjust certain cost CAPs are being made separately). In terms of additional analysis, using the labor cost component as an example, the question is whether the CAP of the 90<sup>th</sup> percentile within the peer group has contributed to the AB 1629 goal of investing in the workforce. (Has staffing increased? Have worker wages and benefits improved? Has turnover been reduced and retention improved?) If AB 1629 goals are not being achieved an assessment of the cause should be made and a determination made of whether the cost component CAP has been an impediment to achieving this goal.

**Impact:** This recommendation involves the need for additional review, analysis, and discussion, therefore outlining a measure is not applicable.

**Costs:** Additional costs associated with continuing the workgroup and internal costs to DHCS and other State agency for staff time associated with AB 1629 Workgroup activities.

**Feasibility:** The recommendation is of importance to ensuring the overall goals of AB 1629 are met and can be sustained. The identified need for additional review, analysis, and discussion meets legislative intent for the AB 1629 Workgroup's established purpose. Therefore, the recommendation should remain a part of the AB 1629 Workgroup's future agenda.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

We do not support extending the workgroup for this purpose. Is there any reason to believe changing the caps will help achieve AB 1629 objectives?

#### ***Provider***

Workgroup provider representatives fully support all of the recommendations related to this category. These recommendations deal with reviewing various operational aspects of the AB 1629 reimbursement methodology including both global and cost component CAPS, peer groupings, and other factors.

*ii. Specifically review the Fair Rental Value System cost component to evaluate its impact in meeting AB 1629 goals of improving resident living and quality of life, and staff working environments. (Providers)*

**General Vote Record**

Yea: 6

Nay: 2

Abstention: 9

**Individual Vote Record**

6 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

2 Nays

2 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Deborah Doctor, Disability Rights California

9 Abstentions

4 Consumers/Advocates

- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Bill Powers, California Alliance for Retired Americans (CARA)

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

**Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** Under the Fair Rental Value System (FRVS) concept, a price (AB 1629 FRVS rate component per diem) is established for the use of space, irrespective of actual cost (lease cost or

ownership). In effect, the facility is leasing space and the use of its assets to the Medi-Cal program. The price paid is based upon the facility value, which can increase over time with proper maintenance, improvements, and upgrades. Since the value of a well-maintained and up to date facility should increase over time, the incentives should be there for both long-term ownership and for maintaining and upgrading the physical plant. The design of the AB 1629 FRVS rate component required the development of a complex financial model using consistent methods and factors for the purpose of identifying a proxy appraisal value for each individual facility. This value (and FRVS rate component per diem) can be increased based on future upgrades and improvements to the facility, which meets certain thresholds. In order to implement AB 1629's FRVS, two specific requirements were outlined: 1) The allocation of funding to the FRVS rate component in the aggregate had to meet budget neutrality upon implementation; and 2) Limitations were required to control annual growth rate. The current average FRVS rate component per diem ranges from \$ 5 to \$7 per day. Recent experience since the implementation of AB 1629 is that the FRVS has not been sufficient to encourage providers to improve infrastructure, purchase new equipment, or facilitate the objectives of the "culture change" movement. Factors beyond the FRVS are also impeding infrastructure improvements as well. These factors include: increased costs resulting from having to meet seismic and other building code requirements under the review and approval process from OSHPD; the lack of access to capital (both today and even prior to the current credit crisis); and the proportion of owned versus leased facilities (many California skilled nursing providers lease facilities). The FRVS, as well as the other factors, have likely played a role in the slow growth of improving skilled nursing facility infrastructure. Because AB 1629 has been in place for more than 3 years, it is time for DHCS and stakeholders to review the impact and effectiveness of the FRVS in meeting AB 1629 goals. Given the importance of this issue, it deserves additional analysis, review, and discussion within the AB 1629 Workgroup.

**Impact:** This recommendation involves the need for additional review, analysis, and discussion, therefore outlining a measure is not applicable.

**Costs:** Additional costs associated with continuing the workgroup and internal costs to DHCS and other State agency for staff time associated with AB 1629 Workgroup activities.

**Feasibility:** The recommendation is of importance to ensuring the overall goals of AB 1629 are met and can be sustained. The identified need for additional review, analysis, and discussion meets legislative intent for the AB 1629 Workgroup's established purpose. Therefore, the recommendation should remain a part of the AB 1629 Workgroup's future agenda.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

We do not support extending the workgroup for this purpose. The recommendation states that recent experience is that the FRVS has not been sufficient to encourage providers to improve infrastructure, purchase new equipment, or facilitate the objectives of the culture change movement. What is the basis for this statement? If reimbursement for this purpose were increased, where would it come from? Providers should be investing their own funds in

improving the infrastructure. If Medi-Cal is paying for infrastructure costs, it should be given an ownership interest in these assets.

***Provider***

Workgroup provider representatives fully support all of the recommendations related to this category. These recommendations deal with reviewing various operational aspects of the AB 1629 reimbursement methodology including both global and cost component CAPS, peer groupings, and other factors.

- iii. *DHCS should revisit the peer grouping and analyze whether the current groupings are appropriately reimbursing facilities in different counties; additionally, a process should be established to review the composition of peer groups at least once every five years to assure that the goal of addressing geographic cost variations is being met. (SEIU)*

**General Vote Record**

Yea: 13

Nay: 0

Abstention: 4

**Individual Vote Record**

13 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

2 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)
- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California

4 Abstentions

4 Consumers/Advocates

- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California

**Supporting Information from Submitting Organization(s) – SEIU**

In our 2002 report SEIU recommended that 13 peer groups be created in the state. DHCS ultimately settled on seven peer groups, but at the time said that it would revisit this issue in the

future. The DHCS should revisit the peer grouping and analyze whether the current groupings are appropriately reimbursing facilities in different counties.

The Department in conjunction with interested stakeholders should review the Peer Group configuration and the department should perform another cluster analysis or other statistical test to determine the most appropriate configuration to achieve the goal of addressing variances in costs. During this review process the following are among the items that should be considered:

- Selecting the most appropriate geographic boundary (County, Health Service Area, Metropolitan Statistical Area, other);
- Whether peer groups should be geographically contiguous;
- Whether a different numbers of peer groups (other than seven) makes more sense;
- Whether “urban” and “rural” designations are necessary to best account for geographic variations in cost;
- Ways to address geographic disparity in wages through the peer group system.

Additionally, a process should be established to review the composition of peer groups at least once every five years to assure that the goal of addressing geographic cost variations is being met.

The current peer grouping raises warning flags on its face. For example, the range in the number of facilities in each peer group varies from under 20 facilities in one peer group to over 330 in another peer group. One area of concern is that the Urban A peer group, which is Los Angeles County, is the largest peer group with over 330 facilities and does not take into consideration the varying degrees of spending amongst facilities within that county. Another concern is that certain counties are designated as Rural, yet the Navigant cluster analysis report contains no methodology on how these designations were assigned.

## **Comments**

### ***SEIU***

SEIU strongly encourages the department in conjunction with stakeholders to review the peer groups since it has been 5 years since they were established and there are concerns with the current composition.

### ***Provider***

Workgroup provider representatives fully support all of the recommendations related to this category. These recommendations deal with reviewing various operational aspects of the AB 1629 reimbursement methodology including both global and cost component CAPS, peer groupings, and other factors.

*iv. Measure and report the impact of the universal cap on Medi-Cal rates. (CCS)*

- Beginning in February 2010, the Department of Health Care Services will report annually to the Legislature (to Health, Aging and Long-Term Care and Budget committees) on the impact of the universal spending caps.

**General Vote Record**

Yea: 7

Nay: 4

Abstention: 6

**Individual Vote Record**

7 Yeas

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

1 Consumers/Advocates

- Bill Powers, California Alliance for Retired Americans (CARA)

4 Nays

4 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Deborah Doctor, Disability Rights California

6 Abstentions

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

1 Consumers/Advocates

- Nina Weiler-Harwell, AARP

### **Supporting Information from Submitting Organization(s)**

AB 1629 includes a provision capping the total increased cost of Medi-Cal reimbursements to skilled nursing facilities from one year to the next. In the early years the caps varied by amount and actual costs did not exceed the cap. In 2008-2009, the cap was set at 5% and spending under the reimbursement formula would have exceeded the cap, so rates across the board were lowered to fit under the legislative cap. State and federal funds are used to fund health care through a wide variety of services and vendors under the Medi-Cal program. Reimbursement fees to these providers and the annual changes in cost are established through the state budget process. Other Medi-Cal services do not have caps on the annual year-to-year cost changes set by statute.

Spending caps create a special hardship for services to seniors for a number of reasons. First, the rate of growth in the number of seniors exceeds the overall population growth and will do so for several decades. The number of seniors will grow from about 4 million to over 12 million in the next several decades, so the potential demand for long term care will grow as well. Second, the cost of health care has increased at a much faster rate than overall cost of living and will likely do so for the foreseeable future. Finally, California's rates for snf reimbursement were among the lowest in the nation before AB 1629 and those rates were not adequate to support important quality improvements such as higher staffing levels. So, given the growing population, the rate of health care inflation and the demand for higher quality care, arbitrary spending caps are inappropriate.

To allow for a better understanding of the impact of the universal spending caps we recommend that, beginning in February 2010, the Department of Health Care Services report annually to the Legislature (to Health, Aging and Long-Term Care and Budget committees) on the impact of the universal spending caps. The report should include at least the following:

- The amount of state and federal money that was not allocated to skilled nursing facilities because of the spending cap in effect (ie, the cost to the General Fund and in FFP if the cap had been removed)
- The number of institutions that were denied funding because of the cap
- The number of patient days in facilities that were denied funding
- The range of rates (and average rate) paid to California facilities compared to rates paid in other states.

This information will equip policymakers and advocates with better information to understand the impact of the universal caps on patient care, institutions, and the patient population. This report would carry administrative costs for compiling and reporting the information, which would be borne by the DHCS. It could be easily implemented.

### **Comments**

*CANHR and Ombudsman & HICAP Services of Northern California*  
California cannot afford to remove the universal cap.

***Provider***

Workgroup provider representatives fully support all of the recommendations related to this category. These recommendations deal with reviewing various operational aspects of the AB 1629 reimbursement methodology including both global and cost component CAPS, peer groupings, and other factors.

**General Comments Regarding Research, Study, Data Collection, and Reporting Category**

***Providers***

Workgroup provider representatives fully support all of the 4 recommendations. These recommendations deal with reviewing various operational aspects of the AB 1629 reimbursement methodology including both global and cost component CAPS, peer groupings, and other factors.

***SEIU***

SEIU supports continued research & evaluation of the AB 1629 reimbursement methodology and its impacts. Although we did not reach consensus on any of the proposed recommendations due to language being too broad or in some cases too specific, we look forward to working with the state and stakeholders to determine which areas are of greatest importance for further evaluation.

#### 4. Category: Licensure, Oversight, and Enforcement

##### Recommendations

- i. Clarify cost categorization and related definitions through adoption of regulations. (Providers)*

##### General Vote Record

Yea: 8

Nay: 0

Abstention: 9

##### Individual Vote Record

8 Yeas

##### 6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

##### 2 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)

9 Abstentions

##### 6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

##### 3 Skilled Nursing Facility Labor

- Dionne Jimenez, SEIU International
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

## **Supporting Information from Submitting Organization(s) - Providers**

**Analysis:** Currently the law, State Plan, and a limited number of Medi-Cal Provider bulletins have been utilized to guide provider supplemental reporting, the audit, and rate setting process. The use of the provider bulletin mechanism to establish and clarify policy has been useful for implementing new programs as it allows DHCS to implement new programs and Medi-Cal policy changes on an expeditious basis. However, it lacks the mechanism required of public input through a regulatory process. The lack of clear policy related to some aspects of AB 1629's reimbursement methodology has resulted in disagreements between audit staff and providers. These disagreements lead to audit appeals and rate calculation errors that could have been avoided had policy been clear. For example, an issue related to the miscategorization of contract staff providing support services within a nursing facility, lead to multiple audit appeals and ultimately required DHCS to amend rates for a large number of providers. The issue could have been avoided if policy guidance had been clarified within regulation or other provider instruction. Given that AB 1629 reimbursement methodology has been implemented and in place for more than 3 years, it is time for DHCS to move forward with the development of regulations in advance of the requirement that they be in place by July 31, 2010 (Welfare and Institutions Code 14126.027 (c)).

### Pros:

- Helps to clarify requirements applicable to all stakeholders including DHCS, providers, and others.
- Helps to improve the accuracy in cost reporting and rate calculation by mitigating questions and misinterpretation related to issues such as cost categorization.
- Reduces the number of audit and rate calculation appeals.

### Cons:

- Requires DHCS to develop and promulgate regulations through a formal rulemaking process.

**Impact:** The impact of this recommendation can be measured internally by DHCS through workload analysis in both the Financial Audits Branch and Medi-Cal AB 1629 Rate Development Unit. After regulations are promulgated, the analysis should focus on whether the numbers of AB 1629 audit and rate calculation appeals have been reduced from levels prior to the time in which the regulations become effective.

**Costs:** The cost to develop and implement regulations is an internal staffing cost to the responsible State department, in this case, DHCS.

**Feasibility:** The recommendation is of immediate importance to ensuring the overall goals of AB 1629 are met and can be sustained. Additionally, implementing the regulation is supported in current law. Given that costs are internal to DHCS and there is no new general fund requirement, there should be no true impediment to implementing this recommendation with the exception of internal workload priorities within DHCS.

## **Comments**

### ***CANHR and Ombudsman & HICAP Services of Northern California***

More information is needed on the nature of the alleged disagreements between audit staff and providers. Should these issues be addressed in statute, as opposed to regulation?

### ***Provider***

Workgroup provider representatives strongly support the recommendation to clarify cost categorization and related definitions through the adoption of regulations.

*ii. Failure to meet the staffing standards should be an automatic B penalty and the amount of a B penalty should be increased. The state should require any nursing home that fails to comply with minimum staffing requirements to submit a report to the department specifying the day and shift on which the noncompliance occurred and the reasons for the noncompliance. (SEIU)*

**General Vote Record**

Yea: 11

Nay: 6

Abstention: 0

**Individual Vote Record**

11 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) – SEIU**

There must also be stronger enforcement of the minimum staffing requirements. Studies show that too many facilities are failing to meet the 3.2 standard. Penalties are inadequate for facilities that staff below the minimum. Failure to meet the staffing standards should be an automatic B penalty and the amount of a B penalty should be increased. The state should require any nursing

home that fails to comply with minimum staffing requirements to submit a report to the department specifying the day and shift on which the noncompliance occurred and the reasons for the noncompliance.

### **Comments**

#### ***Providers***

Workgroup provider representatives reject this recommendation as it relates to regulatory penalties and citations, which are outside of the purview of the workgroup. Citation penalties have nothing to do with the reimbursement methodology of AB 1629. Furthermore, citation fines were significantly increased a few years ago, and there is no evidence that this was an effective deterrent to future non-compliance. While we believe that a fair and reasonable oversight and enforcement system is important, we do not believe that greater enforcement is the key to improved quality.

- iii. *The state’s website should include more information about facility citations and deficiencies, including copies of the citations themselves. In addition, the ratesetting methodology will work best when it is balanced with an appropriate enforcement scheme. Penalty amounts have not been increased in eight years. The penalty for “AA”, “A” and “B” citations should all be increased. (SEIU)*

**General Vote Record**

Yea: 11

Nay: 6

Abstention: 0

**Individual Vote Record**

11 Yeas

6 Consumers/Advocates

- Geneva Carroll, Sacramento Ombudsman, Ombudsman & Health Insurance Counseling and Advocacy Program (HICAP) Services of Northern California
- Mike Connors, California Advocates for Nursing Home Reform (CANHR)
- Nancy Hall, Disability Services and Legal Center
- Nina Weiler-Harwell, AARP
- Deborah Doctor, Disability Rights California
- Bill Powers, California Alliance for Retired Americans (CARA)

5 Skilled Nursing Facility Labor

- Corinne Eldridge, SEIU United Long Term Care Workers (SEIU ULTCW)
- Dionne Jimenez, SEIU International
- Mary Mundy, Member, SEIU United Healthcare Workers West (SEIU UHW)
- Tamara Rasberry, SEIU CA State Council
- Deb Roth, SEIU United Long Term Care Workers (SEIU ULTCW)

6 Nays

6 Skilled Nursing Facilities

- Lori Costa, Aging Services of California
- David Farrell, SNF Management
- Jim Gomez, California Association of Health Facilities (CAHF)
- Jocelyn Montgomery, California Association of Health Facilities (CAHF)
- Darryl Nixon, California Association of Health Facilities (CAHF)
- Michael Torgan, Country Villa Health Services

**Supporting Information from Submitting Organization(s) - SEIU**

The state should do a better job of letting the public know about specific conditions affecting quality and safety in skilled nursing facilities. Specifically, the state’s website should include more information about facility citations and deficiencies, including copies of the citations themselves. In addition, the ratesetting methodology will work best when it is balanced with an

appropriate enforcement scheme. Penalty amounts have not been increased in eight years. The penalty for “AA”, “A” and “B” citations should all be increased.

### **Comments**

#### ***CANHR and Ombudsman & HICAP Services of Northern California***

Additionally, the Legislature should re-establish DPH authority to impose a full ban on admissions to prevent understaffed nursing homes from continuing to admit new residents.

#### ***Providers***

Workgroup provider representatives reject this recommendation as it relates to regulatory penalties and citations, which are outside of the purview of the workgroup. Citation penalties have nothing to do with the reimbursement methodology of AB 1629. Furthermore, citation fines were significantly increased a few years ago, and there is no evidence that this was an effective deterrent to future non-compliance. While we believe that a fair and reasonable oversight and enforcement system is important, we do not believe that greater enforcement is the key to improved quality.

### **General Comments Regarding Licensure, Oversight, and Enforcement Category**

#### ***Providers***

Workgroup provider representatives support recommendation 1 to clarify cost categorization and related definitions through the adoption of regulations, but rejected recommendations 2 and 3 as they relate to regulatory penalties and citations which are outside of the purview of the workgroup. Citation penalties have nothing to do with the reimbursement methodology of AB 1629. Furthermore, citation fines were significantly increased a few years ago, and there is no evidence that this was an effective deterrent to future non-compliance. While we believe that a fair and reasonable oversight and enforcement system is important, we do not believe that greater enforcement is the key to improved quality.

#### ***SEIU***

We encourage the state to review the current enforcement system, and take a closer look at SEIU’s recommendations regarding an automatic B penalty for not meeting minimum staffing standards, as well as recommendations for increasing penalty amounts generally and posting more information on the state website.

**Additional Recommendation Submitted Outside the Workgroup Process**

The Legislature should re-establish DPH authority to impose a full ban on admissions to prevent understaffed nursing homes from continuing to admit new residents. (CANHR)

## IV. Conclusion

In general, each submitted set of recommendations was structured as an integrated approach to improving the legislation. As a result, the process of grouping all submitted recommendations into common issue areas or content categories and then discussing some, but not all, was difficult. Still, the three themes that surfaced during the workgroup process as principal discussion items – quality and the definition of quality indicators, pay-for-performance, and data collection and reporting – proved central in the various perspectives, interests, and positions of different stakeholder groups with regard to issue areas and specific recommendations. Issues areas not uniquely addressing these themes predominantly garnered workgroup member support across the three stakeholder groups. These issue areas included: improving cost reporting methodology; reducing the lag time in facility expenditures and reimbursement; staff training; transitioning residents to the community and assisting in meeting Olmstead requirements; addressing the audit system/process; and developing a system for defining, collecting and reporting data on quality of care and quality of life in skilled nursing facilities. Two recommendations, one from the issue area of improving cost reporting methodology, and one from the issue area of cost reimbursement – timing, had unanimous support: *Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology (p. 26)*; and *Address the time lag of facilities increasing costs and recognition of these costs in Medi-Cal reimbursement rates (p. 40)*. Despite the very important development of consensus on these recommendations and common ground in general on this group of issue areas, time constraints limited the group’s ability to address different perspectives with regard to the specific recommendations in each issue area, as well as how best to implement change in the area.

As issue areas and recommendations touched more specifically on the areas of quality and the definition of quality indicators, pay-for-performance, and the required elements of a new data collection and reporting system (e.g., management fees), members of the stakeholder groups expressed differing perspectives. These issue areas included: payroll reporting, staffing standards, the Labor-Driven Operating Allocation, the Liability Insurance Pass-Through, staff turnover and retention, and management fees. Reaching consensus on specific measures or recommendations in not only these but all issue areas was difficult, and by the conclusion of the workgroup, appeared to be beyond the scope of the workgroup at this time. It should be noted that even in these issue areas there were intersections of agreement and interest among some workgroup members to continue these discussions, in some form, in the future. By the end of the workgroup process, many members indicated that although the process had been difficult, they found the opportunity to understand different stakeholder perspectives and receive important information and data both valuable and positive. In the absence of more developed recommendation proposals at this time, the State is encouraged to continue efforts to improve the timeliness of AB 1629 monitoring, data collection, and reporting.

The following departments are acknowledged for their tremendous work in providing data and information to workgroup members: the California Department of Health Care Services – including Audits and Investigations and Medi-Cal Benefits, Waiver Analysis and Rates Division; the California Department of Public Health; Licensing and Certification; the California Office of Statewide Planning and Development; and, the State Long-Term Care Ombudsman, California Department of Aging. Special thanks must be extended to the members of the AB 1629

workgroup. Despite seemingly insurmountable challenges at times, AB 1629 workgroup members worked diligently and dedicatedly to develop AB 1629/ratesetting methodology recommendations.

## **APPENDIX A: AB 1629 BACKGROUND<sup>lvi</sup>**

### **Pre AB 1629**

Prior to implementation of AB 1629, skilled nursing facilities (SNFs) received a flat rate reimbursement, which was equal to the median cost of facilities in each peer group. Facilities with fewer than 60 beds formed one peer group, and facilities with 60 or more beds formed another peer group. Rates were computed separately for facilities in three separate geographic regions: Los Angeles County, San Francisco County, and the rest of the State. Facilities did not have an opportunity to earn higher reimbursement by expanding staff, services or capacity. This system did not include a quality assurance fee and thus did not maximize federal funding available for quality improvement.

The old methodology had several deficiencies which led the California Association of Health Facilities (CAHF) and the Service Employees International Union (SEIU) to draft AB 1629. The flat rate reimbursement system incentivized providers to contain costs to absolute minimums. The system did not recognize the individual facility cost impact of new mandates or extraordinary cost increases pertaining, for example, to staffing ratios, workers compensation and liability insurance. The system did not promote quality in staff or services and did not provide resources to improve aging facility infrastructure.

### **AB 1629 Intent**

The intent of AB 1629 was to devise a Medi-Cal long-term care reimbursement methodology that would more effectively ensure individuals' access to appropriate long-term care services, promote quality resident care, advance decent wages and benefits for nursing home workers, support provider compliance with all applicable state and federal requirements, and encourage administrative efficiency. AB 1629 imposed a QAF, added requirements for discharge planning and assistance with community transitions, outlined a new cost-based reimbursement methodology, and capped annual rate increases at 5.5 percent.

### **Quality Assurance Fee**

The QAF was intended to generate funds that could be used to enhance federal financial participation dollars in the Medi-Cal program or to provide additional reimbursement to, and support quality improvement efforts in, SNFs. Continuing care retirement communities (multilevel care facilities) and State and other government facilities are exempt from the QAF. Facilities are assessed a 5.5 percent fee based on annual facility revenues excluding Medicare revenue. The QAF is paid on total resident days (including Medicare days). DHCS has the ability to deduct the unpaid fee and any interest owed from future Medi-Cal reimbursements to the facility. If all or part of the fee remains unpaid, DHCS may delay facility license renewal and/or assess a penalty equal to 50 percent of the unpaid fee.

## **Discharge Planning & Olmstead Goals**

AB 1629 contains provisions that support community transitions. The legislation requires SNFs to include in a resident's care assessment their projected length of stay and discharge potential. The bill also requires the attending physician to determine the care needed to assist the resident in transitioning back to the community. Residents are to be evaluated at least quarterly for their capability to return to the community.

## **Reimbursement Methodology**

AB 1629 required DHCS to develop a cost-based reimbursement rate methodology for SNFs. Rates are updated annually and are established based on the most recent cost report data submitted to DHCS. Audits of 100 percent of all facilities are scheduled for the 2008-09 rate year.

The rate methodology developed by DHCS computes a facility-specific, cost-based per diem payment for SNFs based on the sum of five different cost categories described below. Categories are subject to cost limits, and costs specific to one category may not be shifted to another cost category to circumvent the limits, which are set based on expenditures within geographic peer groups.

1. **Labor:** This category has three components: direct resident care labor costs; indirect care labor costs; and a labor-driven operating allocation.
  - Direct resident care labor costs include salaries, wages and benefits related to routine nursing services personnel defined as nursing, social services and activities personnel. These costs are limited to the 90<sup>th</sup> percentile of each facility's peer group.
  - Indirect care labor costs include all labor costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. These costs are limited to the 90<sup>th</sup> percentile of each facility's peer group.
  - Labor-driven operating allocation (LDOA) includes an amount equal to 8 percent of direct and indirect resident care labor costs, less expenditures for agency staffing such as nurse registry and temporary staffing costs. The LDOA cannot exceed 5 percent of the facility's total Medi-Cal reimbursement. Facilities can use the LDOA for allowable Medi-Cal expenditures incurred caring for Medi-Cal residents. The LDOA was initially proposed by the provider community. It is essentially a profit margin that links annual return to labor costs, creating an incentive for facilities to fund staffing and wages for both direct care nursing staff and indirect care. The LDOA was included in the rate methodology based on an industry and union assumption that appropriate staffing levels result in high quality patient care.

2. **Indirect care non-labor:** This category includes the non-labor costs related to services that support the delivery of resident care including: the non-labor portion of nursing; housekeeping; laundry and linen; dietary; in-service education; pharmacy consulting costs and fees; and plant operations and maintenance costs. These costs are limited to the 75<sup>th</sup> percentile.
3. **Administrative:** This category includes allowable administrative and general expenses of operating the facility including: administrator costs; business office costs; home office costs that are not directly charged; and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. These costs are limited to the 50<sup>th</sup> percentile.
4. **Fair rental value system (FRVS):** This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.
5. **Direct pass-through:** This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance, and new state and federal mandates including the facility's portion of the QAF.

## 6. APPENDIX B: WORKGROUP INFORMATION DOCUMENTS AND PRESENTATIONS

The following documents were made available to workgroup members and the public during the AB 1629 Workgroup process (see workgroup website).

### Meeting and Agenda Notices

- January 22, 2009 Agenda
- January 12, 2009 Agenda
- December 17, 2008 Agenda
- December 1, 2008 Agenda
- November 24, 2008 Agenda
- November 19, 2008 Agenda
- November 6, 2008 Agenda

### Workgroup Meeting Minutes

- January 22, 2009 Minutes
- January 12, 2009 Minutes
- December 17, 2008 Minutes
- December 1, 2008 Minutes
- November 24, 2008 Minutes
- November 19, 2008 Minutes
- November 06, 2008 Minutes

### Policy

- Assembly Bill 1183
- Meeting Rules Bagley-Keene Act 2004
- AB 1629 Overview Presentation

### December 17, 2008 Meeting Presentations

- Caregiver Training
- Follow-Up Workgroup Requests
- Satisfaction Turnover and Quality
- Nursing Home Complaints, 2002-2007
- Background on Transitions
- Minimum Data Set 3.0 Implementation Timeline
- Nursing Home Resident, Family and Staff Satisfaction
- State Medicaid Director Letter
- SQM Final Report to CMS
- SQM Final Report to CMS Appendices A-F

### December 17, 2008 Meeting Presentations (cont)

- Workgroup Questions 1
- Workgroup Questions 2
- SUM-DEF-COUNTY
- Citations 2004-2007
- Complaints, Entity Reported Incidents
- Staffing Citations Summary Count
- Complaint Code Definitions
- Indirect Labor
- Direct Labor
- Liability Insurance Per Diem
- Quality Assurance Fee Program
- CPI/AB1629 Rate Comparisons
- Freestanding Adult Subacute Facility Rates, 2005-2009
- Final A&I Response to Questions
- Title 22 51019
- Title 22 51020
- W and I 14171
- SNF Quality Workgroup Data
- JAGS Article
- JAGS Editorial
- Nurse to Patient Ratio Methodology
- Citations 2004-2007
- Complaints, Entity Reported Incidents
- Staffing Citations Summary Count
- Citations 2004-2007
- Complaints, Entity Reported Incidents
- Staffing Citations Summary Count
- Complaint Code Definitions

- SQM Final Report to CMS Appendices G-H

### **Workgroup Documents and Reports**

- AB 1629 Workgroup Questions
- AB 1629 Article Citations-Links
- Overview of SQM Phase I Documents
- Phase I Literature Review
- Final Report and Appendices
- Final Report of Stakeholder Meeting to CMS
- SQM Final Report Exec Summary
- SQM Creation of the NH Staffing DB and Data Dict.
- A&I Response to 11.19.08 Question
- Audits and Percent
- DHCS Response to Workgroup Questions
- Five Cost Categories
- Peer Group List by County
- Fiscal Forecasting Division Response to Workgroup Question
- Staffing and Quality of Care Indicators in SNF, Report to Legislature January 1, 2009
- My InnerView Document 12.11.08
- The California Pathways Report 2.22.08
- December 19, 2008 Citations
- CMS Issues Rating System For Nursing Homes
- QAF Estimated Max Collectable FFP Chart
- Nursing Hours Mandate Chart
- Direct Care Labor Spending Chart

### **AB 1629 September 16, 2008 Meeting**

- AB 1629 September 16, 2008 Embassy Suites, Sacramento Meeting Agenda
- Measuring Quality in Nursing Homes
- Measuring and Improving Nursing Home Quality
- Public Reporting of Nursing Home Quality in California
- Using Payment to Drive Quality Improvement in Medicare and Medicaid
- Improving Quality in Nursing Homes

### **CDPH, Licensing and Certification Responses to Workgroup Questions (12/17/08 Meeting)**

- Profile of SNFs Audited For Compliance FY 2005-2006
- Investigated Complaints-ERIs
- Peer Group Key
- Citations Table FYs 2005-2008
- Deficiencies Peer Group Chart FYs 2005-2008
- Deficiencies Peer Group Table FYs 2005-2008

### **Workgroup Recommendations**

- Opening Remarks For AB 1629 Recommendation Voting Document
- AB 1629 Recommendation Voting Document
- AB 1629 Workgroup Recommendations
- CANHR-AARP-DRA-OSC Recommendations

- CCS Recommendations
- OWL-CCS-CARA Letter
- CAHF Recommendations
- SEIU Recommendations

## **APPENDIX C: AB 1629 WORKGROUP INFORMATION-GATHERING INTERVIEWS**

The AB 1629 Workgroup facilitator conducted brief phone-based information gathering interviews with all members of the AB 1629 Workgroup during the early phase of the workgroup process. The purpose of the interviews was to assist the facilitator with understanding both the complexity of AB 1629 and the unique experiences of workgroup stakeholders with respect to the legislation. Each member was asked the following questions:

- Please describe your individual as well as representative group (labor, facilities, consumer/advocates) experiences with AB 1629.
- What do you hope the workgroup will accomplish?

Members expressed different perspectives, experiences, and interests, as well as common ground issues with regard to AB 1629 and their charge as workgroup members. Represented below are the core issues (with member comments) that reflected member diversity of opinion and common ground:

### **Issues Reflecting Diverse Perspectives**

#### **1. Current and proposed modifications to AB 1629 payment methodologies, cap rates, and reimbursement processes.**

*Eliminate caps, the labor-driven operating allocation, and the liability insurance pass-through.*

*Raise caps, increase staffing ratios and salaries, and reduce payment lag time.*

*Restructure peer groups.*

*Maintain opportunities for capital improvements.*

#### **2. Improving quality of care for nursing home residents.**

*Employ pay-for-performance.*

*Create employer incentives.*

*Tie all reimbursement to meeting staffing and turnover standards.*

## **Issues Reflecting Common Ground**

### **1. Improve quality of care and quality of life for all nursing home residents.**

*Quality of care and quality of life for nursing home residents demand equal attention.*

*Nursing home residents need our support.*

### **2. Improve the State's nursing home data collection and reporting processes.**

*Better data collection procedures and more timely data dissemination by the State would help with both monitoring and promoting quality in nursing homes.*

Many members indicated that the AB 1629 Workgroup process offered a valuable opportunity to gather information and hear different stakeholder voices. Note: findings are from the phone-based interviews and do not reflect workgroup discussions or recommendations.

## REFERENCES

- <sup>i</sup> Harrington, C., O'Meara, J., Collier, E., et al., *Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality and Costs*. Department of Social & Behavioral Sciences, University of California San Francisco, 2008. The study was supported by funds from the California HealthCare Foundation.
- <sup>ii</sup> Schnelle, J., Mukamel, DB., Sato, HW., et al. *Evaluation of AB 1629*, 2008.
- <sup>iii</sup> "Trends in Nursing Home Deficiencies and Complaints," OEI-02-08-00140, Office of Inspector General, Department of Health and Human Services, September 18th, 2008. <http://oig.hhs.gov/oei/reports/oei-02-08-00140.pdf>
- <sup>iv</sup> The average Medi-Cal rate for a freestanding skilled nursing facility has increased from \$118.06 in FY 03-04 to \$161.81 in FY 08-09.
- <sup>v</sup> DHCS handout to workgroup on the quality assurance fee.
- <sup>vi</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 30. It is likely that the figures in this report represent the number of complaint allegations rather than the number of complaints. In a separate document provided to the workgroup, DPH reports that public complaints grew from 4,920 in 2004 to 5,593 in 2007, an 11 percent increase.
- <sup>vii</sup> Attachment I, DPH handout provided at the December 17, 2008 workgroup meeting.
- <sup>viii</sup> Attachment I, DPH handout provided at the December 17, 2008 workgroup meeting.
- <sup>ix</sup> Attachment I, DPH handout provided at the December 17, 2008 workgroup meeting.
- <sup>x</sup> Attachment I, DPH handout provided at the December 17, 2008 workgroup meeting.
- <sup>xi</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 35.
- <sup>xii</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 31.
- <sup>xiii</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 30.
- <sup>xiv</sup> Nursing Home Compare, [www.medicare.gov](http://www.medicare.gov).
- <sup>xv</sup> Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.
- <sup>xvi</sup> Audits and Investigations Response to Workgroup Questions, December 1, 2008, pages 1-2.
- <sup>xvii</sup> Cultural, linguistic, and disability competency were added as an addendum to the recommendation.
- <sup>xviii</sup> CMS 2008 Action Plan for Nursing Home Quality. See also, *Development of Staffing Quality Measures - Phase I: Continuation, Final Report*, May 2, 2008, and *Development of Staffing Quality Measures - Phase I, Final Report*, July 25, 2005.
- <sup>xix</sup> DPH handout to workgroup.
- <sup>xx</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 13.
- <sup>xxi</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 18.

- <sup>xxii</sup> OSHPD handout, December 17, 2008.
- <sup>xxiii</sup> U.S. Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc., 2001, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final*. Volumes I-III. Baltimore, MD: CMS.
- <sup>xxiv</sup> OSHPD handout, December 17, 2008.
- <sup>xxv</sup> 22 CCR §72329.
- <sup>xxvi</sup> OSHPD handout, December 17, 2008. It reports that in 2007, California SNFs averaged 1.11 hprd of licensed nurse staffing (0.32 RN and 0.79 LVN).
- <sup>xxvii</sup> California Department of Public Health, Notice of Public Availability of Proposed Changes to Emergency Regulations and Supporting Documents and Information Regarding Skilled Nursing Facility Nursing Staff-to-Patient Ratios, DPH-03-010E, October 16, 2008.
- <sup>xxviii</sup> OSHPD handout, December 17, 2008.
- <sup>xxix</sup> OSHPD handout, December 17, 2008. It reports that RN hours in California SNFs have remained almost unchanged since 2002, when 0.31 hprd were provided. In 2007, 0.32 hprd were provided.
- <sup>xxx</sup> AB 1629's discharge planning requirements are established in section 1418.81 of the Health and Safety Code. Federal guideline *F250 for 42 C.F.R. § 483.15* refers to "Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities)."
- <sup>xxxi</sup> DHCS handout on Labor-Driven Operating Allocation distributed at the December 1, 2008 workgroup meeting. It reports that Medi-Cal spent \$153.6 million on the LDOA in FY 05-06, \$153.6 million in FY 06-07 and \$156.4 million in FY 07-08. Medi-Cal paid additional funds through the LDOA to freestanding subacute SNFs.
- <sup>xxxii</sup> DHCS handout on Labor-Driven Operating Allocation distributed at the December 1, 2008 workgroup meeting. It projects that Medi-Cal will spend \$168.4 million on freestanding SNFs through the LDOA in FY 08-09. Medi-Cal is paying additional funds through the LDOA to freestanding subacute SNFs.
- <sup>xxxiii</sup> DHCS handout on Professional Liability Insurance distributed at the December 1, 2008 workgroup meeting.
- <sup>xxxiv</sup> 2007.08 Final Rates, DHCS website at: <http://www.dhcs.ca.gov/services/med-cal/Pages/LTCAB1629.aspx>
- <sup>xxxv</sup> OSHPD handout, December 17, 2008.
- <sup>xxxvi</sup> OSHPD handout, December 17, 2008.
- <sup>xxxvii</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, pages 24-27.
- <sup>xxxviii</sup> Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.
- <sup>xxxix</sup> *People of the State of California vs. John Douglas Lund, Centurion Healthcare, Inc. et al*, Felony Complaint, Case No. 08F09994, Sacramento Superior Court, December 7, 2008.

<sup>xl</sup> *People of the State of California vs. John Douglas Lund, Centurion Healthcare, Inc. et al*, Declaration in Support of Arrest Warrant and Summons on Felony Complaint, Case No. 08F09994, Sacramento Superior Court, December 7, 2008.

<sup>xli</sup> Welfare & Institutions Code §14126.023(h).

<sup>xlii</sup> December 30, 2008 e-mail to workgroup members from Barbara Bailey, Chief, Medi-Cal Benefits, Waiver Analysis and Rates Division.

<sup>xliii</sup> Audits and Investigations Response to Workgroup Questions, December 1, 2008, pages 1-2.

<sup>xliv</sup> Audits and Investigations handout, How Do We Know if the Audit System is Working, November 26, 2008.

<sup>xlv</sup> Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.

<sup>xlvi</sup> Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.

<sup>xlvii</sup> DHCS handout, 2008/09 Estimated Program Expenditures. It states that administration expenditures increased by 12 percent since 05-06, expenditures on other costs increased by 13 percent since 05-06 and direct/indirect non-labor cost expenditures increased by 20 percent since 05-06.

<sup>xlviii</sup> OSHPD Handout, December 17, 2008.

<sup>xlix</sup> Satisfaction as Measures of Quality, Workgroup Handout, December 17, 2008 (listed on the AB 1629 Website as *Satisfaction Turnover and Quality*: [www.dhcs.ca.gov/services/medical/Pages/SNFQualityWorkgroup.aspx](http://www.dhcs.ca.gov/services/medical/Pages/SNFQualityWorkgroup.aspx))

<sup>l</sup> Recommendations *i* and *ii* were initially grouped in Subsection A but were subsequently moved to Subsection B, Category: Reimbursement/Ratesetting/QAF Methodology after it was determined they no longer fit the criteria for Issue Areas with Multiple Recommendations.

<sup>li</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 21.

<sup>lii</sup> DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 22. It shows that inflation adjusted wages for CNAs decreased from \$10.08 in FY 03-04 to \$10.02 in FY 07-08.

<sup>liii</sup> SEIU underwent an organizational change after the Subsection A voting; as a result, five voting members are recorded for Subsection B, with the exception of Recommendations *i* and *ii* in the Category: Reimbursement/Ratesetting/QAF Methodology.

<sup>liv</sup> Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 2.

<sup>lv</sup> LAO report “Overview of the Governor’s Special Session Proposals” November 11, 2008, page 25.

<sup>lvi</sup> Prepared by DHCS, 2008.