

**SKILLED NURSING FACILITY QUALITY WORKGROUP
MEETING SUMMARY**

Monday, January 12, 2009

10:15 A.M. – 3:15 P.M.

University of Southern California State Capitol Center
1800 I Street, Sacramento, CA 95814

Attending Stakeholder Workgroup Members:

Geneva Carroll, Sacramento Ombudsman, Ombudsman & HICAP Services of No. CA

Mike Connors, California Advocates for Nursing Home Reform (CANHR)

Lori Costa, Aging Services of California

Deborah Doctor, Disability Rights Association

Corinne Eldridge, Service Employees International Union (SEIU)

David Farrell, SNF Management

Jim Gomez, California Association of Health Facilities (CAHF)

Nancy Hall, Disability Services and Legal Center

Dionne Jimenez, Service Employees International Union (SEIU)

Jocelyn Montgomery, California Association of Health Facilities (CAHF)

Mary Mundy, Service Employees International Union (SEIU)

Darryl Nixon, California Association of Health Facilities (CAHF)

Tamara Rasberry, Service Employees International Union (SEIU)

Deb Roth, Service Employees International Union (SEIU)

Richard Thomason, Service Employees International Union (SEIU)

Michael Torgan, Country Villa Health Services

**Nina Weiler-Harwell, American Association of Retired Persons (AARP)

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

**Betty Perry, Older Women's League

**Gary Passmore, Congress of California Seniors

** Represents the four rotating members of Stakeholder Group: only two members of this rotating group were represented at the table at any one time.

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)

Monique, Parrish, Facilitator

Joseph Rodrigues, Department of Aging, Office of State Long-Term Care Ombudsman, participated by phone

I. Welcome/Review Agenda

The sixth AB 1629 Workgroup meeting opened with member and public introductions followed by a review of the agenda (see attached). The focus of the meeting was continued discussion and refinement of Workgroup Objectives 2 & 3:

- Objective 2: Define a process for reviewing information and making recommendations.
- Objective 3: Establish a process for reviewing the final set of recommendations for the workgroup summary report, with public input.

The facilitator noted that following introductory agenda items, Ty Christensen, Office of Statewide Planning and Development (OSHPD), would present his responses to member data requests and questions. Once concluded, the facilitator indicated the stakeholder groups, which submitted AB 1629/Ratesetting recommendations, would provide a review of their of their recommendations highlights, and then the full membership would discuss the process for organizing and formally reviewing the recommendations.

II. Review Summary of 12/17/08 Meeting

No edits were offered for the summary report of the AB 1629 workgroup 12/17/08 meeting.

III. Status of Outstanding Issues/Requests

The facilitator reported a name correction for the California Advocates for Nursing Home Reform (CANHR), previously identified, on numerous AB 1629 Workgroup documents, as the California Association of Nursing Home Reform.

Members were encouraged to submit all data information inquires via e-mail to: snfquali@dhcs.ca.gov. Additionally, members were encouraged to continue using the Workgroup website to review posted information: <http://www.dhcs.ca.gov/services/medical/Pages/SNFQualityWorkgroup.aspx>

Public Comment

A member of the public inquired about the format of the AB 1629 Workgroup Report. *Facilitator Response*: The report will capture the Workgroup process and outcomes and will be written by the facilitator; however, Workgroup members and the public will be invited to submit recommendations regarding formatting and content.

IV. Information Requests Presentation:

Ty Christensen, Office of Statewide Planning and Development (OSHPD)

Ty Christensen's presented a 16-page handout addressing data requests and questions for OSHPD. A summary of the presentation discussion highlights, by page section, follows:

Page1: Discharges by length of stay and discharge location – in the 5+-year row for 2007 there was a misreport by one chain of facilities; OSHPD is looking into the issue.

Q: I don't see a trend for more people discharged home related to time or length of stay – not much progress in discharge to hospital or death.

- *Comment:* But you can't say there isn't progress getting people out facilities unless you look at the patients and see if they can move.
- *Comment:* That is the reason for a transition program that's adequately funded.

A: We have to be careful not to try to get too much out of the data.

- *Comment:* There is a lot of patient turnover in nursing homes – there is a huge population that spends 1 week to 30-45 days in the facility. Nursing homes have become the subacute facilities because insurance companies are pushing people from hospitals to nursing homes to get the cheaper stay for rehab – this is different from the long-term care framework we've been using.

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Q: what does the residential board and care asterisk mean?

A: I don't know.

Q: Given increases in the number of spaces in residential board and care facilities, why aren't we seeing an increase in the number of people discharged to these facilities?

- *Comment:* the state has very limited assisted living programs; the bigger issue is that nobody has the job of getting people out except for the few people who work in small transitions programs. Another important issue is who can afford assisted living?

Page 2: Average staffing below and above 3.2 minimum – based on yearly average of nursing hours.

- No questions on this chart.

Pages 3-4: Nursing hours per patient day broken down by staff type.

- 1629 effects would show up at the end of 2005 or sometime in 2006.

Pages 5-6: Hourly rates by staff type. The trend is up in all categories – RN goes up a bit steeper. Numbers aren't inflation adjusted.

- *Comment:* I compared OSHPD's numbers to the numbers in DPH's report to the Legislature. The salary figures are slightly different, but both show increases prior to 1629. The two different reporting systems showed a significant increase in salaries over time, demonstrating the impact of 1629.
- *Comment:* There were comparable wage increases pre and post 1629.

Pages 7-8: Employee turnover.

- There were large decreases overall in turnover.

- *Comment:* Turnover in some peer groups increased between 2006 and 2007.
Comment: Those that went up were largely rural (3) -- the urban groups have decreased turnover and they are driving down the trend.
- *Comment:* The largest decrease in turnover was right before 1629 so the effects of the legislation in this area remain debatable.
- *Comment:* Hours are up, wages up, turnover down – we don't have the best correlation analysis in the world – but we do know that there has been movement in the right direction in four key variables related to AB 1629.
Response: But, have they moved enough?
- *Comment:* A fair question, but a different question.

Pages 9-12: Nursing labor costs per patient day

Pages 13-14: Cost breakdowns

- Too unwieldy to break down by peer groups
- Pass through costs are captured with administration. Administrator's salaries are included.
- Administration cost has had the greatest percent increase.

Q: Do percents matter as opposed to the real dollars going into the system?

- *Comment:* With percent increases, we have to remember that there are cost caps; these are total dollars – not capped dollars – so 41.62 is not really what was paid.
- *Comment:* Yes, but there are some direct pass-throughs so we can't draw a conclusion.

Pages 15-16: Financial ratios.

- Medi-Cal non-allowable costs for home offices were taken out of the charts in the right hand column. Operating margin is net income divided by reported expenses. Current ratio is current assets divided by current liabilities (current year).
- *Comment:* this doesn't mean a whole lot because you don't have the money now since state payments are slow to come in. Cash flow will continue to be an issue in the foreseeable future – running a business is about all the charts in total and you can't ignore that cash flow with the state is an issue.
- *Response:* But, you can't ignore that the operating margin has increased post 1629.
- *Comment:* But of all the providers, nursing facilities are the lowest on operating margins. Pre-1629 about 15% of the industry was bankrupt. You want stability in the operating margin so that the business can function – 0.02 as an operating margin doesn't allow you to do anything.

- *Comment:* an operating margin under 5% doesn't allow anyone to invest. Increase in operating margin is reflective of increase in Medicare Part A occupancy, which influences the margin as much as anything else.
- *Comment:* I have no problem with a healthy operating margin – I just want to make sure that quality is going up as well.

A: Regarding a return on assets and capital assets – we haven't seen the expenditures yet on investment in property but that's not surprising since it takes time to make capital improvements.

Public Comment

1. I would like to see wage changes in real dollars. Also, not everyone agrees that this bill has worked the way it was supposed to, so I don't like members commenting, "we all know" when referencing the legislation or the intent of the legislation. Please respect all points of view.
2. On page 14 are training costs just for RN's and LVNs? *TC:* the cost is just for the trainer not the trainee – just the cost of providing the training – OSHPD doesn't collect data on who gets training.
3. Isn't it cheaper for people to live in assisted living or live independently than to live in a facility?

Richard Thomason, SEIU, asked to distribute a handout, "CMS Nursing Home Compare: Five Star Quality Ratings," addressing the ten largest nursing home chains in California. Several members voiced concerns about both the data collection process and the methods for determining the ratings. The facilitator requested that Mr. Thomason refrain from distributing the handout but did note that members interested in the document could obtain one from Mr. Thomason at the break.

A Workgroup member reminded the group that personal comments such as "you don't understand" were inappropriate and best if eliminated from discourse. The facilitator duly noted this recommendation.

V. Continue Discussion and Refinement of Objectives 1,2,&3

After discussing the best approach for advancing the discussion on the Workgroup objectives with particular attention to developing AB 1629/ratesetting methodology recommendations, members elected to have each organization/group submitting recommendations present (highlights) of their respective recommendations. Before moving to this item, several members raised the issue of Pay-For-Performance (P4P), noting that many of the submitted recommendations involved P4P, although it was an issue previously "taken off the table" by Workgroup consensus. A robust discussion ensued about P4P. Providers stated that they had not pursued P4P recommendations in light of their understanding that it was no longer a viable issue for the group. Several providers stated that it was their recollection that the Workgroup acknowledged the merits of P4P but equally acknowledged that the State did not, at this time, have the

infrastructure to move to a P4P system with AB 1629. Other members indicated that they were confused by the discussion and the exact definition of P4P. One participant reported that he understood “off the table” as a temporary suspension of the discussion. The facilitator apologized for the confusion and asked that the group move forward in the interest of time. The group agreed to this and suggested that those members reporting recommendations: 1) tag P4P recommendations; and 2) provide a timeframe for implementation for P4P recommendations.

A. SEIU presented its recommendations:

- 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.
- 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.
- The state should require payroll data reporting for purposes of enforcement of staffing requirements and more updated labor cost reporting into the rate system.
- 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.
- 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.
- 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.

- Address the time lag of facilities increasing costs and recognition of these costs in Medi-Cal reimbursement rates.
- 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.
- Reimburse liability insurance costs as an administrative cost in the administrative cost center, where it would be subject to the 50th percentile cap.
- Identify appropriate costs for Olmstead implementation that could be reimbursed separately from other costs. These costs should be reimbursed as a pass-through in order to provide greater incentives for assisting residents in transferring 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 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.
- 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.
- 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.

- Increase Quality Assurance Fee revenues; the quality assurance fee should be extended to a facility's Medicare revenues.
- 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.
- Recover Rate Overpayments to SNFs.
- Ratesetting, following a Change of Ownership (CHOW), should be consistent when a facility has submitted six months of its own data.
- Have appeal information publicly available on the AB1629 website
- Redesign the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report.

SEIU indicated that their recommendations were a living document, affording them the right to make changes.

Question/Answer Period:

Q: Were implementation timelines considered?

A: They are not in the document but SEIU is considering them. SEIU is still working to finalize recommendations.

Q: Were you thinking of a quarterly report system for staffing?

A: Yes – something like that.

Q: The turnover recommendation sounds like P4P.

A: Could take out the reward but our intent was to get the state to look at and help facilities address turnover.

Q: Did you consider another way to deal with outliers in professional liability insurance such as going after the outlier rather than capping costs for the entire group?

A: The cap could be a cost savings in bad budget times - we think this is the way to do it.

Q: Regarding the turnover recommendation - who would work with the facilities?

A: Probably L&C.

Q: Shouldn't staff satisfaction be a key component of the workgroup?

A: The state should evaluate it and if they think it's important it should be in there.

Q: Regarding the quality assurance fee – have you thought of a different way of coming at the formula or were you worried that there weren't parameters?

A: We want DHCS to see if 40% is still appropriate and where the cut off should be.

Q: We see a lot of common ground particularly around the 3.5 nursing hours but how would you propose to fund it?

A: Several answers – we need to look at facilities that would/would not be at 3.5. We would propose using savings from some of the other recommendations to fund it.

- *Comment:* The savings is a cut from one pot to place in another. *Response:* We would fund it by raising new revenues and redirecting others, not by savings.

Q: How do quality of care committees fit into the reimbursement model?

A: Could be part of a P4P system down the road.

Q: Did you think about protecting the data shared in the quality of care committee?

A: We have not discussed this in depth, but it's a valuable point about confidentiality protections.

BREAK FOR LUNCH

B. Letter from OWL, CARA, CCS:

A letter from the organizations of OWL, CCS, and CARA was presented. The letter follows. No questions were raised.

For more than ten years, members of the California Alliance for Retired Americans, the Congress of California Seniors and the Older Women's League have come to the legislature supporting bills, which we thought would improve the care given in nursing homes. We have been continually disappointed. We found that enforcement of bills was not adequately funded so our efforts were fruitless. Even as we supported AB 1629, we have had enforcement problems. These are concerns we should address as we report to the legislature.

When AB1629 was developed, the Older Women's League, the California Alliance for Retired America, the Congress of California Seniors and Gray Panthers believed by supporting the bill it would improve nursing home care. Our concern was based on our concern for improving the status of nursing home workers, the first line of defense for nursing home care. Inadequately paid workers were often working two shifts and were not as reliable as is needed

When AB1629 came into being, we found that there was practically universal support in the legislature, and the bill moved to the Governor and was signed. Then came the problem of dividing the increased funds for the bill. One thing that was surprising was how slowly it seemed to be funded. But the funding was complicated. The process was new. There were a number of areas that were specifically funded and accountability became a problem. Nursing home have no

t had a good reputation for their use of money. Most of the nursing homes dealing with patients under AB 1629 are MediCal eligible homes, which have a regular stream of funding from MediCal.

We wanted the homes to provide safe care, adequate meals and programs to help the residents improve as much as possible. As we have watched AB 1629 move forward, we find that the accounting seems slow, caused by the complications of the bill. This is an area that needs to be clarified. Who gets paid for what and when? When pay is delayed, it is easier for accountability to be difficult.

There are particular reforms that we still are questioning. Data show the importance of adequate skilled nurses on staff. Is this issue being emphasized? What is the staffing ratio for skilled nurses in each residence? Are there specific differences of payment to nursing homes based on staffing levels?

Has the state allowed enough money to pay for adequate inspections?

Are we really looking at nursing homes as places where people will get the rehabilitative care they need to live on their own or are we considering nursing homes as facilities for custodial care? We have observed good therapy in nursing homes, but that seems limited by Medicare and MediCal to people who can improve. Will enforcement of the Olmstead decision make the requirement for more training possible?

If we expect that a patient is not able to return home, what is being done to make the person's life worthwhile? Is there help with mobility problems for patients with limited ability to walk? Are patients encouraged to walk? Are the nursing aides trained to be especially thoughtful and kind to those patients, even the cranky ones? If the aide has trouble speaking English, what is being done to help the patient respond? If the patient does not speak English, is there someone to communicate with that person?

What are we doing about violations? These have been reported to be increasing. Are facilities that have records of violations and inadequate care receiving any kind of rate penalty?

There is little comment about food. What are we doing about being sure the patient has a healthy and pleasing diet? Does the staff, including the management, speak with family members about any problems with the patient's care?

We need to get the issues clarified so we can all move forward. California will not be having fewer nursing home residents as the baby boomers age.

The California Alliance for Retired Americans (CARA), the Congress of California Seniors, and the Older Women's League are grateful for all of the time and energy the Department of Health Services is putting into the improvement of nursing home care. Our members are well acquainted with nursing homes for their family members care. They know the pain that inadequate, indifferent or unsatisfactory care

can bring to patients and their families. With this background in mind we would like you to remind you again that we have followed nursing home legislation in the Capitol for many years. We have seen similar bills but without the benefits in AB1629 come, pass, and then nothing happens. From the beginning, we were and still are hopeful for AB1629. It has brought additional attention and funding to the care of nursing home patients. It brought additional funding into the program. We have been pleased to respond to the request about our thoughts on the progress, which the bill is making.

This workgroup has made many strong suggestions to point the way. We hope the legislature will appreciate the progress that has been made and will encourage the work to continue, for there is still much more to be done.

C. Congress of California Seniors (CCS) presented its recommendations:

- 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.
- Create a new state minimum-staffing standard for registered nurses in skilled nursing facilities – we recommend a .32 hour pp/pd standard for RNs.
- Increase the percentile cap for direct patient care staff to create an incentive to increase wages and benefits for that staff.
 - 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.
- Adjust the reimbursement methodology and reporting requirements for costs associated with transitioning patients to community based care.
- Adjust the reimbursement methodology and reporting requirements for liability insurance.
 - 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.
- Shorten the lag time between facility expenditures and Medi-Cal reimbursement rate adjustments.
- We recommend 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.

- 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.
- Develop a system for defining, collecting and reporting data on quality of care and quality of life in skilled nursing facilities; 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.
- 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.

Gary Passmore of CCS noted that these recommendations are his and his alone. He stated that his recommendations did not address P4P, clarifying that tying payment to inputs is not P4P; tying payment to outputs (e.g. bedsores) is P4P. He further noted that the State's fiscal situation would largely dictate the ultimate outcomes for the Workgroup. He then made the following points regarding his recommendations:

- Labor-Driven Operating Allocation (LDOA): Nothing magic about the presented LDOA numbers. Just a way to spread another 5% of LDOA for movement in staffing above 4.1 hours. This system requires monthly tracking of census and staffing which will cost facilities and staff – it could be easy after a little upfront work
- Minimum Staffing Standards: No new funding tied to this recommendation.
- Increasing Percentile Cap for Direct Patient Care: Change direct care cap from 90th to 95th and tie percentile increase to increase in average compensation. This recommendation costs money, which should come with/from higher state funds rather than shifting money under the existing cap.
- Liability Insurance: For the record, CCS is very concerned about not recognizing liability insurance; the organization wants families to have access to the legal system if there is a problem with care.
- Transitioning Patients to Community: Wants to promote the idea of using a stakeholder group to identify the real costs and activities pertaining to Olmstead.
- Lag-Time in Reimbursement: This is a high priority recommendation because the payment lag has distorted the response to 1629. If the State were in a

better financial position, CCS would recommend eliminating the caps. His organization strongly opposes spending cap for any programs for seniors.

- System for Defining, Collecting, Reporting Data: The emphasis for this recommendation is patient satisfaction, not patient and employee satisfaction.

Question/Answer Period:

- *Comment*: LDOA would have to be a monthly rate setting system – this isn't practical.

Q: Who would monitor the self-insurance plan?

A: L&C since it would be a requirement for licensure.

Q: Do you have an estimate on raising the cost cap?

A: That would be driven by expenditures and the economy. We should control the expenditures through the budget process not through arbitrary caps. Expenditures should be negotiated using a more sophisticated method.

- *Comment*: The cap operates separate from population growth.

D. Providers presented their recommendations:

- Advance timing for cost recognition when determining annual AB 1629 facility-specific rates. (Immediate)
- 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. (Immediate)
- Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology. (Immediate)
- Clarify cost categorization and related definitions through adoption of regulations. (Immediate)
- 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. (Immediate)
- 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. (Immediate)

- Increase the reimbursement rate to 100% of costs for RN direct care staffing and Gerontological Nurse Practitioner services in nursing homes. (Immediate)
- Consider establishing a combined rate review process and audit appeal process. (Deserves Further Study)
- Review impact of current cost component caps in meeting AB 1629 goals in improving resident quality of care. (Deserves Further Study)
- 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. (Deserves Further Study)
- 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. (Deserves Further Study)
- Increase the rate of nursing home administrator salary and benefit costs to the 90th percentile. (Deserves Further Study)

Reviewing their recommendation highlights, providers noted that AB 1629 was doing what it was intended to do - retention is up, staffing is up, salaries are up, compliance with 3.2 hours is up. They noted that while acuity is going up over time some key metrics are also improving, in spite of this reality. For example, use of restraints is down, incidence of bedsores is down or neutral, pain management is better controlled. In addition, providers cautioned Workgroup members to be mindful of the State's inconsistent survey process, citing two factors 1) since 1629 money started flowing there have been more nurse surveyors; and 2) CDPH was required to clear their backlog of complaints.

Providers made the following points regarding their recommendations:

- Cost Recognition: Common ground here. Could implement with next rate cycle.
- AB 1629 Sunset Date: We want a permanent structure in place with review and reporting.
- Improve Cost Reporting Methodology: Common ground on this issue.
- Clarify Cost Categorization: The provider bulletin process leaves a lot of grey area. We want to move to a regulatory process so that all parties know the rules.
- Health Information Technology (HIT): We recognize the importance of HIT and the benefit of safety as well as the potential to reduce costs. We don't think however that AB 1629 today gives enough of an incentive for HIT adoptions. We

are also concerned for workers' safety and see the potential of equipment to reduce workers compensation costs.

- Caregiver Training: Common ground on this issue. We tried to build training incentives into 1629, but this component hasn't worked the way it should have (cited another state in which survey results were used by the licensing and certification program to identify target areas for training).
- RN Reimbursement Rates: Given the evidence that RNs make a substantial impact on patients, their costs should be 100% pass through. Nursing facilities have to compete for the limited pool of nurses that are paid better in other areas.
- Rate Review Process: This may overlap with SEIU's recommendation relative to increased transparency.
- Cost Component Caps: Would like to study these. Maybe certain inputs, such as raw food, could move to a pass-through.
- Uniform Data Collection: This may be a quick fix but we need to do it in a way that everyone thinks is reliable and accurate.
- Fair Rental Value System (FRVs): The FRVS was implemented because the flat rate system didn't work. There are caps in the FRVS that providers don't come close to hitting, but people are uncomfortable with putting more money in this cost center. They aren't sure what the answer is but we do know we need to do something differently.
- Nursing Home Administrators: We recommend studying paying administrators at the 90th percentile to attract master's trained administrators.

Question/Answer Period:

Q: What are the caps in the FRVS?

A: There is cap on how you are reimbursed. If you buy 100 new beds and you can expense them, that's one thing. If you buy 100 beds and only get \$5000 a year back, you'll behave differently.

Q: Regarding HIT pass-through – what type of quality improvements are you referring to? Is this a pass through for P4P?

A: Information technology, beds – we hope that the pass-through would improve quality of care.

Q: The proposal says that the recommendation for advanced timing for cost recognition is budget neutral. This means there will be winners and losers since some people will hit the cap. So what's the incentive to make the improvement?

A: Our perspective is that the right people will get the money – they won't get everything reimbursed but they will get more than under the current system.

- *Discussion*: Toby Douglas noted that if rates are at the cap, it's a zero sum game for providers. If costs continue to exceed the cap significantly, it could increase pressure on the state to raise the cap.

Q: What does 100% of RN costs really mean and what does reasonable costs mean?

A: They would look at what ever it costs to bring in the RN considering what peer group you're in. But you do have to ensure it's reasonable because some organizations do offer excessive bonuses and other perks as a recruiting tool.

- *Comment:* We don't want to start wars between nursing homes for staffing

Q: You don't talk about enforcement at all.

A: The charge is reimbursement not regulatory action. Not sure that sticks are the most effective tools to improve performance.

Q: Is there anything that wouldn't be allowable with respect to training?

A: There should be more study. We want it to be broad enough to capture some of the out of the box thinking like management training, etc., to provide an incentive to do really good training.

Q: It's good to understand what satisfaction is, but what do you do about people who game the system and what methodology will you use to capture this?

A: You use a third party – could be OSHPH or any other firm – and you mandate facility participation.

BREAK

E. Consumers (CANHR, Disability Rights California, Ombudsman & HICAP Services of No. CA, AARP, Disability Services and Legal Center):

Section A

- Repeal the labor driven operating allocation established at Welfare & Institutions Code §14126.023(c)(3).
- Condition rate increases on compliance with minimum staffing requirements.
- Repeal direct pass-through payment of liability insurance costs and impose reasonable cost controls on liability insurance.
- 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.
- Cap management fees to parent corporations and salaries of owners and their families.

Section B

- 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.
- Require skilled nursing facilities to report staffing information from payroll records on a quarterly basis.

- Require operators to increase caregiver wages and benefits annually by at least the percentage of rate increase.
- Provide a financial incentive in the rate system to reduce turnover and improve retention of nursing staff.

Section C

- Alternatively, the Legislature should use savings from the repeal of the labor driven operating allocation to prevent cuts to community-based long-term care services.

Section D

- The Legislature should strengthen the Medi-Cal audit system for skilled nursing facilities by:
 - i. Requiring facility cost reports to specifically capture management fees to corporate offices and other corporate office costs.
 - ii. Requiring and funding home office audits to review corporate office expenses.
 - iii. Requiring nursing home chains to be audited as a group.
 - iv. Requiring field audits once every two years and desk audits during intervening years.
 - v. Requiring cost reports to be synchronized with the AB 1629 rate system.
 - vi. Requiring DHCS to establish measures on audit system impact and report them on Medi-Cal's AB 1629 webpage.
 - vii. Establishing clear definitions and providing clarification on problematic terminology.
 - viii. Requiring that rate adjustments based on audit appeals be paid within the overall cap.

Section E

- The Legislature should take the following actions to bring California into compliance with the Supreme Court's Olmstead decision

Short-term recommendations:

1. 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:
 - a. Restore or prevent cuts to community services used by people who otherwise would use nursing homes.
 - b. 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.
- c. Establish a diversion program modeled after successful programs in other states. For instance, Washington state staff give residents and patients onsite help in skilled nursing facilities and hospitals to identify options, enroll in community services and to transition from nursing homes.
 - d. Enhance the Home Upkeep Allowance.
 - e. Strengthen enforcement of state and federal discharge planning requirements. 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.
 - f. In addition to the MDS, the state should require use of other tools that have been created to identify a resident's interest in returning home and the suitability of the transition.

On a longer-term basis, the state should:

1. 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.
2. Identify goals for California's long term care system that eliminate incentives for institutionalization and establish meaningful choices for consumers.
3. Explore whether California can save money by procuring more Medicare funds for nursing home stays, as Connecticut has done.

Consumers made the following points regarding their recommendations:

Section A

- LDOA: There is no justification for keeping the LDOA, especially now. We would like to reinvest the money.
- Liability Insurance: We share some of the recommendations made by others. We don't think the pass through is the right place for this. We think the pass through is for things that facilities can't control, but liability insurance costs are related to performance. We agree with other recommendations on minimum requirements for liability insurance.

- Legal Fees for Appeals: We do not want the state to subsidize facilities' costs in appealing enforcement actions. We support due process, but the state shouldn't subsidize it.
- Management Fees: The system needs reasonable caps. They estimate savings at \$200 M or more to be reinvested in other nursing facility expenditures.

Section B

- Staffing: The chart titled "estimated increase in FFS, managed care..." seems to show that increase in staffing requirements to 3.5 hours would cost about \$250 M. We don't think we can keep LDOA and increase staffing level.
- Payroll Data: CMS has done a lot of work in this area that we agree with; we think DPH should use this as an enforcement tool. DHCS should use the opportunity to comment on this system while it's in development.
- Increase Caregiver Wages: This recommendation grows out of concern that AB 1629 did not succeed in raising CNA wages. We always thought one of the core principles of AB 1629 was to raise these wages.
- Financial Incentive to Reduce Turnover: This issue warrants more workgroup discussion on methodology.

Section C

- Regarding repealing the LDOA - we don't want to take away funds from nursing facilities – we just want them to be put to better use.

Section D

- Regarding Medi-Cal Audit System - there is a lot of common ground on making sure facilities are spending money appropriately

Section E

- Regarding Compliance with Olmstead – as a background for the short- and long-term recommendations in this area, Deborah Doctor made the following remarks:
 - AB 1629 isn't limited to nursing facilities. State General Fund dollars for facilities come from the same pot that home and community-based services have to compete for. Some states are doing global long-term care budgets that fund all facilities and HCBS programs.
 - The money from the freeze on institutional care spending should fund the short-term recommendations.
 - We think it is appropriate for funding to be attached to person rather than location of care because no one should be in a nursing facility if they don't have to be. All of the evidence we have shows that a certain significant percent of people in facilities want to go to the community.

- The best people to help transition are the experts in the community. California's experience and the experiences of other states in transitioning individuals from institutional care to the community, demonstrates that there is a role for community services to work with facility staff to help transitions.
- We encourage everyone to talk to Megan Juring's (CA Health and Human Services Agency) counterpart in Washington State. Washington gives preference to community services and they have worked with the community to make strides in this area.
- Finally, this isn't everything – it is Phase One. For example, we want to see more training for CNAs and more enforcement of access to facilities for people on Medi-Cal. We don't want facilities to be able to take more people when they are understaffed.

Question/Answer Period:

Q: Did you take into account that if we took away the 4% operating margin, facilities would go bankrupt?

A: No – we don't see it that way?

Q: How does a freeze improve quality of care?

A: If cuts can't be avoided, we would recommend that LDOA be spent differently, used for example for staffing.

Q: Have you taken into account a QAF on other providers to generate funds?

A: It wouldn't work in IHSS although it has been considered over the years. Toby Douglas reminded the group that only certain provider classes that can be taxed.

Q: What about trying to maximize federal funds for Medicare days?

A: Deborah Doctor is looking into it.

Q: Don't see how a lot of these recommendations will improve quality.

A: We want to redirect less productive spending.

Q: Are you saying that just paying more will increase quality?

A: We don't think it's the only thing, but it's important. For instance, when CNAs have to work 2 jobs, quality suffers.

- *Comment:* When you talk about CNAs leaving facilities to go somewhere else, it always comes back to the administrator. To keep good staff, you have to have a good administrator.
- *Response:* The freeze is a worst-case scenario. If DHCS has other ideas about how to avoid the types of cuts that are on the table for other providers, the consumers would like DHCS to present them at the next meeting.

Q: Do you think industry will continue to support QAF if LDOA goes away?

A: We think the industry should be able to bear it.

The Workgroup concluded the presentation of recommendations and moved to a discussion of first whether the issue of P4P should be revisited and second the process for organizing submitted recommendations. Members elected to bypass another meeting devoted to P4P, despite concerns from several members including Toby Douglas who voiced concern that CAHF may have P4P recommendations it has not put forward. A discussion on the topic ensued. Below are several comments made by members regarding this issue and how best to proceed:

- Michael Connors: If CAHF would like to submit P4P recommendations they should do so.
- Deborah Doctor: It would be helpful to read what the P4P definition is but it is not appropriate to spend 6 hours on this area when we did not give equal time to other issues such as Olmstead.
- Jim Gomez: I recommend we just talk about what's on the table now. We passed the P4P window, so we're better prepared to take what's on the table and debate those issues.
- Gary Passmore: I suggest the group focus on data collection addressing quality issues for the next three years and then focus on P4P.

In sum, members agreed: 1) not to provide additional time to address P4P; and 2) not to debate current recommendations employing a P4P approach.

Regarding the second issue – how best to organize submitted recommendations, members agreed to have the facilitator organize the recommendations, to begin to cluster those recommendations with consensus or near-consensus and provide a baseline document for review at the final meeting scheduled for January 22, 2009.

Note: Richard Thomason indicated that he was still looking for methodology for staffing ratio cost estimation. Toby Douglas and Pam Dickfoss indicated they would follow up with this request.

VI. Develop Meeting Agenda for January 22, 2009

The meeting agenda for 1/22/09 was previously developed; hence the facilitator reviewed the main elements of the agenda, outlined below:

- Continued development of AB 1629 workgroup recommendations
- Discussion of Workgroup Summary Report
- Final closing remarks and summary meeting process evaluation

Public Comment

Nina Weiler-Harwell noted she was not part of the earlier P4P discussion but wanted to state she was not sure if the discussion could have been done in the workgroup process. She commented that AARP has its own thoughts about how to do P4P.

Randy Hicks: Olmstead and community transitions have to be part of the report.

VII. Closing Remarks and Meeting Evaluation

The facilitator summarized the meeting, encouraged members to complete the evaluations, and reminded the Workgroup that the first order of business at the next meeting will be to develop a process for discussing and voting on the recommendations.

Prior to closing, Workgroup member Mary Mundy indicated that she was hearing a disregard for CNAs in the Workgroup discussions; she noted that she doesn't know any RN who actually touches a patient. Jim Gomez responded that the whole reimbursement system was founded on respecting CNAs.

VIII. Adjournment

SKILLED NURSING FACILITY QUALITY WORKGROUP
AGENDA

Monday, January 12, 2009

10:15 a.m. to 3:15 p.m.

University of Southern California State Capitol Center
1800 I Street Sacramento, CA 95814

Call-in information is as follows:

Dial in Number 1-877-917-7131

Participant Pass code 1629

Welcome	Monique Parrish (MP), Facilitator
Review agenda	MP
Review summary of 12/17/08 meeting	MP
Status of outstanding issues/requests	MP
Public comment	MP
Discussion of 1) quality measures, including key indicators and (2) regulatory compliance and consequences for noncompliance.	outcomes, and
Continue discussion and refinement of Objectives 2 & 3:	MP
➤ <u>Objective 2</u> : Define a process for reviewing information and making recommendations.	
➤ <u>Objective 3</u> : Establish a process for reviewing the final set of recommendations for the workgroup summary report, with public input.	
Public comment	MP
Develop AB 1629/ratesetting methodology recommendations	MP
Public comment	MP
Develop meeting agenda for January 22, 2009 meeting	MP

Public comment MP

Closing remarks and meeting evaluation MP

Public comment MP

Adjournment

Notes:

Morning and afternoon breaks will be included as part of this agenda.

A working lunch is scheduled - lunch is provided for the Workgroup only.

NEXT MEETING: January 22, 2009 10:15 a.m – 3:15 p.m.

P.M.