

Recommendations for AB 1629 Workgroup Review from the Congress of California Seniors

1. Revise the Labor Driven Operating Allocation currently used in Medi-Cal rate reimbursements.

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 90th 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:

- The LDOA should be divided into two parts: one part for meeting state staffing mandates and one part for staffing at levels above the minimum.
- 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 1/12th, 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.

2.Create a new state minimum staffing standard for registered nurses in skilled nursing facilities.

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.

3. Increase the percentile cap for direct patient care staff to create an incentive to increase wages and benefits for that staff.

The current rate methodology provides for reimbursement of actual spending on direct patient care staff up to the 90th 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 (recommendation 1) and increases in compensation (recommendation 3). 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 Recommendation 7). 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.

4.Adjust the reimbursement methodology and reporting requirements for liability insurance.

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.

5.Adjust the reimbursement methodology and reporting requirements for costs associated with transitioning patients to community based care.

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 95th 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 95th 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.

6. Shorten the lag time between facility expenditures and Medi-Cal reimbursement rate adjustments.

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.

7.Measure and report the impact of the universal cap on Medi-Cal rates.

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.

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

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 1st 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.