AB 1629 Workgroup Recommendations Document

For the
AB 1629 Workgroup Meeting
January 22, 2009

TABLE OF CONTENTS

Prepared by:

Monique Parrish, DrPH, MPH, LCSW

LifeCourse Strategies

AB 1629 Workgroup Recommendations Document

INTRODUCTION

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]

Workgroup members submitted AB 1629/ratesetting methodology recommendations for group review at the January 12, 2009 Workgroup meeting. The purpose of this document is: 1) to highlight issue areas in which recommendation consensus exists or may be achieved; and 2) to provide Workgroup members with a baseline document for reviewing AB 1629/ratesetting methodology consensus and non-consensus recommendations during the final AB 1629 Workgroup meeting, scheduled for January 22, 2009. This working document organizes recommendations from the four sets of recommendations submitted and the number of member votes associated with each set. Each set is referenced in the document by the designated acronym or listing (see Legend below). Issues receiving 11+ votes are presented in Section I, followed by issues receiving 7-10 votes in Section II, followed by issues with standalone recommendations – issue areas with recommendations that did not overlap with those proposed by one or more of the other groups – in Section III. Issue areas with recommendations that appear to have consensus or near-consensus are primarily listed first in Sections I and II. An appendix for each section lists each recommendation as originally submitted (i.e., with supporting information, analyses, costs, etc.). Note: representative votes per issue area were counted only once for submitting parties in Sections I and II, independent of whether multiple recommendations were submitted.

Legend

1. **Congress of California Seniors =** (***CCS) (1 Vote)***
2. **California Advocates for Nursing Home Reform (CANHR), AARP, Disability Rights California and Ombudsman & HICAP Services of Northern California =** ***(CANHR et al.) (4 Votes)***
3. **California Association of Health Facilities, Aging Services of California, Country Villa Health Services, SnF Management =** ***(Providers) (6 Votes)***
4. **Service Employees International =** ***(SEIU) (6 Votes)***

I. Common Issue Areas with Stakeholder Recommendations: 11+ Votes

A. Cost Reporting – Methodology (16 Votes)

- Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology. (Providers)
- Require facility cost reports to specifically capture management fees to corporate offices and other corporate office costs. (CANHR et al.)
- Require cost reports to be synchronized with the AB 1629 rate system. (CANHR et al.)
- Redesign the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report. (SEIU)

B. Cost Reimbursement – Timing (13 Votes)

- Shorten the lag time between facility expenditures and Medi-Cal reimbursement rate adjustments. (CCS)
- Advance timing for cost recognition when determining annual AB 1629 facility-specific rates. (Providers)
- Address the time lag of facilities increasing costs and recognition of these costs in Medi-Cal reimbursement rates. (SEIU)

C. Staff Training (12 Votes)

- 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)
- 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. (SEIU)

D. Payroll Reporting (11 Votes)

- Require skilled nursing facilities to report staffing information from payroll records on a quarterly basis. (CANHR et al).

- 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)

- 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. (CCS)

E. Staffing Standards – RNs/LVNs (11 Votes)

- 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)

- 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. (CANHR et al)

- 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)

F. Transitioning Residents to the Community/Compliance with Olmstead (11 Votes)

- Adjust the reimbursement methodology and reporting requirements for costs associated with 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.

- 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. (CANHR et al.)

- 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. (SEIU)

- 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)

G. Labor-Driven Operating Allocation (11 Votes)

- 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)

- Repeal the labor-driven operating allocation established at Welfare & Institutions Code §14126.023(c)(3). (CANHR et al.)

    - 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.

- 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)

H. Liability Insurance Pass-Through (11 Votes)

- 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.

- Repeal direct pass-through payment of liability insurance costs and impose reasonable cost controls on liability insurance. (CANHR et al.)

  - 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.

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

II. Common Issue Areas with Stakeholder Recommendations: 7-10 Votes

A. Staff Turnover/Retention (10 Votes)

- Provide a financial incentive in the rate system to reduce turnover and improve retention of nursing staff. (CANHR et al)

- 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)

B. Audit System/Process (10 Votes)

- CANHR et al. proposed the following audit system/process recommendations:

  - *Require and fund home office audits to review corporate office expenses.*

  - *Require nursing home chains to be audited as a group.*

  - *Require field audits once every two years and desk audits during intervening years.*

  - *Require DHCS to establish measures on audit system impact and report them on Medi-Cal's AB 1629 webpage.*

  - *Establish clear definitions and provide clarification on problematic terminology.*

  - *Require that rate adjustments based on audit appeals be paid within the overall cap.*

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

C. Management Fees (10 Votes)

- Cap management fees to parent corporations and salaries of owners and their families. (CANHR et al)

- 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)

D. Staff Wages and Benefits (10 Votes)

- Require operators to increase caregiver wages and benefits annually by at least the percentage of rate increase. (CANHR et al.)

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

E. Data Collection/Quality of Care/Quality of Life (7 Votes)

- 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. (CCS)

- 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)

III. Other Issue Areas

A. Reimbursement/Ratesetting/QAF Methodology

- 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. (CANHR et al)

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

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

- Recover Rate Overpayments to SNFs. (SEIU)

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

- Condition rate increases on compliance with minimum staffing requirements. (CANHR et al)

    - 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.

- 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)

- 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)

- 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.

B. State Processes and Procedures

- 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)

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

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

C. Research, Study, Data Collection and Reporting

- Review impact of current cost component caps in meeting AB 1629 goals in improving resident quality of care. (Providers)

- 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)

- 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)

- 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.

D. Licensure, Oversight, and Enforcement

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

- 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)

- 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)

APPENDIX A: COMMON ISSUE AREAS WITH STAKEHOLDER RECOMMENDATIONS: 11+ VOTES

Cost Reporting Methodology (16 Votes)

Providers

Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology.

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.

CANHR et al.

Require facility cost reports to specifically capture management fees to corporate offices and other corporate office costs.

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.[i] This oversight should be corrected so that Medi-Cal can determine when corporations are diverting funds intended for care.

CANHR et al.

Require cost reports to be synchronized with the AB 1629 rate system.

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."[ii] 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.

SEIU

Redesign the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report.

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.

Cost Reimbursement – Timing (13 Votes)

CCS

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.

Providers

Advance timing for cost recognition when determining annual AB 1629 facility-specific rates.

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.

SEIU

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

Staff Training (12 Votes)

Providers

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.

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.

SEIU

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.

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.

Payroll Reporting (11 Votes)

CANHR et al.

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

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.[iii] 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.[iv] 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.[v] 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,[vi] 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.[vii]

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.

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.

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.

CCS

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. (CCS)

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.

Staffing Standards – RNs/LVNs (11 Votes)

CCS

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.

CANHR et al.

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.

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, Statues 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.[viii] 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,[ix] 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.[x] The proposal to require at least 1.0 hprd by licensed nurses is slightly less than current average nurse staffing levels[xi] 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.[xii]

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,[xiii] less than half of the recommended 0.75 hprd. California skilled nursing facilities have not improved RN staffing since AB 1629 was implemented.[xiv] 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.

SEIU

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 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.

Transitioning Residents to the Community/Compliance with Olmstead (11 Votes)

CCS

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.

CANHR et al.

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:

Short-term recommendations:

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.[xv] 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.

SEIU

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 department should work with interested stakeholders to 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. As discussed more fully below, Olmstead

implementation needs to be a high priority and the nursing home industry is uniquely placed to play an important role.

SEIU

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 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.

Labor-Driven Operating Allocation (11 Votes)

CCS

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:

- 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.

CANHR et al.

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

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.[xvi] Additionally, Medi-Cal projects that the labor-driven operating allocation will cost it about $180 million during FY 08-09.[xvii]. 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.

CANHR et al.

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.

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.

SEIU

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.

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.

Liability Insurance Pass-Through (11 Votes)

CCS

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.

CANHR et al.

Repeal direct pass-through payment of liability insurance costs and impose reasonable cost controls on liability insurance.

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,[xviii] 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.[xix] 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.

SEIU

Reimburse liability insurance costs as an administrative cost in the administrative cost center, where it would be subject to the 50th percentile cap.

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.

APPENDIX B: COMMON ISSUE AREAS WITH STAKEHOLDER RECOMMENDATIONS: 7-10 VOTES

Staff Turnover/Retention (10 Votes)

CANHR et al.

Provide a financial incentive in the rate system to reduce turnover and improve retention of nursing staff.

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.[xx] Turnover rates for licensed nurses declined from 57.98 percent in 2004 to 53.84 in 2007.[xxi]

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.[xxii] 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.

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.

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.

Audit System/Process (10 Votes)

CANHR et al.

The Legislature should strengthen the Medi-Cal audit system for skilled nursing facilities by:

Requiring and funding home office audits to review corporate office expenses.

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.[xxiii] This oversight should be corrected.

Requiring nursing home chains to be audited as a group.

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.[xxiv] 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.[xxv]

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

Requiring field audits once every two years and desk audits during intervening years.

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.[xxvi]

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.[xxvii] 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.

Requiring DHCS to establish measures on audit system impact and report them on Medi-Cal's AB 1629 webpage.

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.

Establishing clear definitions and providing clarification on problematic terminology.

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."[xxviii] 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.

Requiring that rate adjustments based on audit appeals be paid within the overall cap.

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."[xxix] It reports that unknown consequences to the general fund have occurred due to this shortcoming of the system.

The Legislature should correct this problem.

Providers

Consider establishing a combined rate review process and audit appeal process.

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.

Management Fees (10 Votes)

CANHR et al.

Cap management fees to parent corporations and salaries of owners and their families.

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.[xxx] They state that the 50th percentile cap on the administration cost component is relied upon for cost control.[xxxi] 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.[xxxii] OSHPD reports that operating margins and operator returns on assets have also risen steeply since AB 1629 was enacted.[xxxiii] 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.

SEIU

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.

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.

Staff Wages and Benefits (10 Votes)

CANHR et al.

Require operators to increase caregiver wages and benefits annually by at least the percentage of rate increase.

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.xxxiv Adjusted for inflation, CNA wages actually decreased during this same period.xxxv

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.

Providers

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

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 GNPs 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.

Data Collection/Quality of Care/Quality of Life (7 Votes)

CCS

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.

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.

Providers

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.

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.

APPENDIX C: OTHER ISSUE AREAS

Reimbursement/Ratesetting/QAF/ Methodology

CANHR et al.

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.

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.[xxxvi] These guidelines are insufficient because they do not address legal fees related to inspection and investigation findings.

Providers

Increase the rate of nursing home administrator salary and benefit costs to the 90th percentile.

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 contigent 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 50th percentile. This has a limiting effect on the ability of facilities offer competitive wages to high performing administrators. Increasing the reimbursement rate from the 50th percentile to the 90th 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.

SEIU

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

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.[1]

SEIU

Recover Rate Overpayments to SNFs.

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.

SEIU

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

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.

CANHR et al.

Condition rate increases on compliance with minimum staffing requirements.

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.

[1] LAO report "Overview of the Governor's Special Session Proposals" November 11, 2008, page 25.

Providers

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.

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.

SEIU

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.

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.

CCS

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.

State Processes and Procedures

Providers

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.

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.

SEIU

Have appeal information publicly available on the AB1629 website.

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:
  a. Cost Center category or categories involved in the appeal;
  b. Additional monies received by the facility for each cost center and the date received; and
  c. In each Cost Center category where an appeal was granted, the specific reason for granting the appeal.

Providers

Clarify cost categorization and related definitions through adoption of regulations.

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.

Research, Study, Data Collection and Reporting

Providers

Review impact of current cost component caps in meeting AB 1629 goals in improving resident quality of care.

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^{th} 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.

Providers

Specifically review the Fair Rental Value System (FRVS) cost component to evaluate its effectiveness and impact in meeting AB 1629 goals of improving resident living environment, quality of life, and staff working conditions.

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 where 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.

SEIU

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.

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.

CCS

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.

Licensure, Oversight, and Enforcement

Providers

Clarify cost categorization and related definitions through adoption of regulations.

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.

SEIU

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.

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.

SEIU

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 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.

REFERENCES

[i] Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.

[ii] Audits and Investigations Response to Workgroup Questions, December 1, 2008, pages 1-2.

[iii] 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.

[iv] DPH handout to workgroup.

[v] DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 13.

[vi] DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 18.

[vii] OSHPD handout, December 17, 2008.

[viii] 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.

[ix] OSHPD handout, December 17, 2008.

[x] 22 CCR §72329.

[xi] 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).

[xii] 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.

[xiii] OSHPD handout, December 17, 2008.

[xiv] 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.

[xv] 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)."

[xvi] 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.

[xvii] 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.

[xviii] DHCS handout on Professional Liability Insurance distributed at the December 1, 2008 workgroup meeting.

[xix] 2007.08 Final Rates, DHCS website at: http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx

[xx] OSHPD handout, December 17, 2008.

[xxi] OSHPD handout, December 17, 2008.

[xxii] DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, pages 24-27.

[xxiii] Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.

[xxiv] *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.

[xxv] *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.

[xxvi] Welfare & Institutions Code §14126.023(h).

[xxvii] December 30, 2008 e-mail to workgroup members from Barbara Bailey, Chief, Medi-Cal Benefits, Waiver Analysis and Rates Division.

[xxviii] Audits and Investigations Response to Workgroup Questions, December 1, 2008, pages 1-2.

[xxix] Audits and Investigations handout, How Do We Know if the Audit System is Working, November 26, 2008.

[xxx] Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.

[xxxi] Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.

[xxxii] 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.

[xxxiii] OSHPD handout, December 17, 2008.

[xxxiv] DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 21.

[xxxv] 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.

[xxxvi] Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 2.