AB 1629 Provider Workgroup Recommendations

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

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

3. **Improve and update the current cost reporting methodology – (Immediate)**

4. **Clarify cost categorization and related definitions through adoption of regulations – (Immediate)**

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

6. **Expand and redefine the care giver training pass-through component to be a 100% reimbursement of costs for all training to nursing home staff that is directly related to the quality of resident care and services. Require the California Dept of Public Health, Licensing and Certification program to review survey and Quality Measure data at least once a year in order to identify and recommend priority training topics for skilled nursing staff – (Immediate)**

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

8. **Consider establishing a combined rate review process and audit appeal process – (Deserves further study)**

9. **Review impact of current cost component caps in meeting AB 1629 goals in improving resident quality of care – (Deserves further study)**

10. **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 publically reported measures in California (Deserves further study)**

11. **Specifically review the Fair Rental Value System cost component to evaluate its impact in meeting AB 1629 goals of improving resident living and quality of life, and staff working environments - (Deserves further study)**

12. **Increase the rate of nursing home administrator salary and benefit costs to the 90th percentile – (Deserves further study)**

1/9/09

AB 1629 Workgroup Provider Recommendation # 1
Cost Recognition

Recommendation: 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.

AB 1629 Workgroup Provider Recommendation # 2 – Sunset

Recommendation: 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.

AB 1629 Workgroup Provider Recommendation # 3 – Cost Reporting

Recommendation: 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, neither 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.

AB 1629 Workgroup Provider Recommendation #4 - Regulations

Recommendation: 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.

AB 1629 Workgroup Provider Recommendation # 5
Equipment and Information Technology

Recommendation: 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.

AB 1629 Workgroup Provider Recommendation #6 - Training

Recommendation: 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.

AB 1629 Workgroup Provider Recommendation # 7 – RN Staffing

Recommendation: Increase reimbursement rate to 100% of costs for RN direct care staffing and Gerontological Nurse Practitioner (GPN) 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 off-set 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.

AB 1629 Workgroup Provider Recommendation # 8
Combined Rate Review and Audit Appeal Process

Recommendation: Consider establishing a combined rate review 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. become effective.

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.

AB 1629 Workgroup Provider Recommendation # 9 Cost Caps

Recommendation: 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 90th 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.

AB 1629 Workgroup Provider Recommendation # 10
Satisfaction Surveys

Recommendation: 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.

AB 1629 Workgroup Provider Recommendation #11
Fair Value Rental

Recommendation: 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.

AB 1629 Workgroup Provider Recommendation # 12
Administrator Cost

Recommendation: Increase the rate of reimbursement 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 turn-over 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.