SEIU AB 1629 Taskforce Recommendations
(DISCUSSION DRAFT January 12, 2009)

SEIU appreciates the opportunity to submit the following preliminary recommendations to the AB 1629 taskforce for discussion. After we have initial discussions with the taskforce, we reserve the right to modify these recommendations before the taskforce votes on them and for items where there is not taskforce consensus we reserve the right to modify recommendations before final inclusion in the report to the legislature.

Background

The quality of care provided in California nursing homes remains unacceptably low. Too often the frailest and most vulnerable seniors and the disabled fail to get high quality nursing home care. The evidence presented to the Nursing Home Stakeholder Workgroup shows that in recent years some important quality metrics have shown slow improvement. Too many others have shown no improvement or give evidence of declining quality of care. This is intolerable in a period during which the profit margin of California nursing homes has increased substantially.

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

- Increasing numbers of complaints made to the state's Long-Term care Ombudsman and to the Department of Public Health, despite a declining number of nursing home admissions and a flat trend in Medi-Cal patient days. From 2002-03 to 2006-07, the number of complaints to the Long-Term Care Ombudsman rose by 16 percent. From 2004 to 2007 the number of complaints to the Department of Public Health rose by almost 14 percent, while the number of substantiated allegations rose by 77 percent. The total number of state citations issued to nursing homes rose by 48 percent from 2004 to 2007.

- According to a 2008 report by the Office of the Inspector General of the federal Department of Health and Human Services, the percentage of California nursing homes surveyed that received federal deficiency notices rose from 98.6 percent in 2005 to 99.1 percent in 2007, and the average number of deficiencies found per surveyed facility rose from 10.2 to 11.8. California had a higher proportion of nursing homes with deficiencies in 2007 (99.1%) than the national average of 91.9 %, and a higher average number of deficiencies per facility, 11.8, than the national average of 7.[1]

- The recent release of the five-star rating system by the federal Centers for Medicare and Medicaid Services (CMS) also illustrates the overall quality problems of California nursing homes: over 44 percent of California nursing homes were rated worse than average (having one or two stars out of five). California ranked 23rd out of 51 states and the District of Columbia on having the highest proportion of facilities with one star while ranking 36th in the proportion of facilities that had five stars.

[1] "Trends in Nursing Home Deficiencies and Complaints," OEI-02-08-00140, Office of Inspector General, Department of Health and Human Services, September 18th, 2008. http://oig.hhs.gov/oei/reports/oei-02-08-00140.pdf

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

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

Employee turnover, while dropping in recent years, is also still too high. Although turnover fell in recent years, in 2007 annual turnover for nursing employees was still over 50 percent. Consistent, person-centered care simply cannot be provided by a workforce that is continually changing. Turnover is lowest in the peer group – peer group 7, the Bay Area – with among the highest wages, the highest levels of staffing and the most unionization. Much of this turnover is due to the fact that in recent years earnings for nursing assistants, after inflation, have stayed flat - according to the CDPH report, inflation-adjusted earnings (wages, salaries and benefits) for nursing assistants actually declined slightly, from $10.08 in 2001-02 to $10.02 in 2007-08.

Recommendations

1) **Staffing.** 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.

Encourage Facility Quality of Care Committees

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.

2) **Improve enforcement of staffing requirements.** 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.

   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.

   Increase Enforcement and Increase Transparency: 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.

3) **LDOA**: The 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.

4) **Turnover**: 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.

5) **Liability insurance**: 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.

6) **Address the time lag of facilities increasing costs and recognition of these costs in Medi-Cal reimbursement rates:** As discussed above, 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.

7) **Olmstead implementation costs**: 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.

8) **Increase Efforts to Return Nursing Home Residents to Home and Community Based Settings:** 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, the result will be readmissions and higher acuity. Proper care planning is essential.

9) **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.

10) **Peer Groups**: 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.

11) **Increase Quality Assurance Fee 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.[2]

12) **Administration**: 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.

13) **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.

14) **Rates for Facilities with a Change of Ownership (CHOW):** 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.

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

15) **Appeals on Facility Rates:** 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.

16) **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.