

# AB 1629 OVERVIEW

Presented by Toby Douglas

Department of Health Care Services

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# PRE AB 1629

- ❖ Flat Rate Reimbursement
  - ❖ Flat-Fee Calculated at Median of All Costs for Facilities Located Within Specified Geographic Areas and Licensed Bed-Size
  - ❖ No Incentive to Provide Higher Level of Care
- ❖ No Quality Assurance Fee
- ❖ Minimal Audit Adjustment Appeals
- ❖ Rates frozen for the 2004/05 Rate Year

# Pre-AB1629 Medi-Cal Reimbursement Rates for SNFs (state-wide weighted average rates)

Year	Rate	Increase
1995	\$79.71	0%
1996	\$81.13	1.78%
1997	\$83.12	2.45%
1998	\$88.71	6.73%
1999	\$91.32	2.94%
2000	\$110.27	20.75%
2001	\$112.93	2.41%
2002	\$113.73	.71%
2003	\$118.06	3.81%
2004	Rates frozen at	2003 level

# AB 1629 OVERVIEW

- September 29, 2004 – AB 1629 approved and filed with Secretary of State (Chapter 875, 2004, AB 1629, Frommer)
- Removed 2004-05 Rate Freeze (NF B)
- Outlined new facility-specific (NF B) reimbursement methodology (1,000+ facilities)
- Enacted a NF B Quality Assurance Fee (QAF) to provide funding
- Added requirement to the Health and Safety Code for discharge plan and assistance when resident has potential and desire to return to the community
- System evaluation required (BSA Audit)
- Original sunset date July 31, 2008 (AB 203, health trailer bill 2007 extended sunset date to July 31, 2009)

# INTENT OF AB 1629?

- More effectively ensures individual access to appropriate long-term care services
- Promotes quality resident care
- Advances decent wages and benefits for nursing home workers
- Supports provider compliance with all applicable state and federal requirements
- Encourage administrative efficiency.

# INTENT OF AB 1629?


- Provide reimbursement to Skilled Nursing Facilities (SNF) that support quality improvement efforts
- Establish reimbursement methodology that encourages and rewards SNFs to invest more in direct care labor
- Impose a quality assurance fee to enhance federal financial participation
- Encourage capital investment



# QAF KEY POINTS

- ❖ Quality Assurance Fee (QAF)
  - ❖ Fee amount updated annually
    - ❖ Based on aggregate facility revenue (net of Medicare revenue)
  - ❖ Some facilities exempt – Hospital DP, CCRC, Multi-level Retirement, IMDs
    - ❖ Annual process for requesting exemption (CHOWs, bed/room composition, governance)
  - ❖ Payments Due Monthly – Last day of following month
  - ❖ Paid on total resident days

# FIVE COST CATEGORIES

- ❖ Labor
    - ❖ Direct Care Labor (reimbursed up to 90<sup>th</sup> percentile)
    - ❖ Indirect Care Labor (reimbursed up to 90<sup>th</sup> percentile)
    - ❖ Labor Driven Operating Allocation (calculated at 8% Direct and Indirect Care Labor Costs...capped at 5% of total M'Cal reimbursement rate)
  - ❖ Indirect Care Non-Labor (reimbursed up to 75<sup>th</sup> percentile)
  - ❖ Administrative (reimbursed up to 50<sup>th</sup> percentile)
  - ❖ Capital Costs (FRVS Calculation)
  - ❖ Pass-Through Costs (100%, Professional Liability Insurance, Caregiver Training, License Fees, Quality Assurance Fee)
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# COST BUILD-UP

Reimbursement Rate = Sum of projected cost of the following cost components.

- ✓ Labor
- ✓ Indirect Care non-labor
- ✓ Administration
- ✓ Capital / FRVS
- ✓ Pass-Through Costs



# Maximum Annual Rate Increase (Rate Caps per Statute)

Rate Year	Maximum Increase
2005-06	8%
2006-07	5%
2007-08	5.5%
2008-09	5.5%
2009-10	5%
2010-11	5%

# AB 1183 Health Trailer Bill of 2008

- Extends AB 1629 methodology through July 31, 2011
- Establishes 5% overall rate cap increase for the 2009-10 and 2010-11 rate years
- Provides for the establishment of the Stakeholder Workgroup



# Stakeholder Workgroup

- 18 members
- Meet at least 6 times by December 31, 2008
- Make recommendations to DHCS including future rate methodologies needed to improve and assure quality of care
- DHCS must forward recommendations and responses to Legislature by March 1, 2009
- Comprehensive Review:
  - Quality-of-care measures
  - Staffing and pay
  - Enforcement and compliance
  - Impact on care of the rate methodology

QUESTIONS?

