

Consumer Recommendations to Reform AB 1629
Submitted to the AB 1629 Workgroup on January 12, 2009

The following recommendations are supported and endorsed by California Advocates for Nursing Home Reform (CANHR), AARP, Disability Rights California, Ombudsman Services of Northern California, and Disability Services & Legal Center.

Under AB 1629, annual Medi-Cal spending on skilled nursing facility care has increased by about \$1 billion and average rates have increased by 37 percent.¹ Of that \$1 billion in new spending, only \$282 million comes from the Quality Assurance Fee;² the remainder comes from the California General Fund and federal funds.

Despite the enormous infusion of taxpayer funds, AB 1629 has not achieved its intent of ensuring individual access to appropriate long-term care services, promoting quality resident care, advancing decent wages and benefits for nursing home workers, supporting provider compliance with all applicable state and federal requirements, and encouraging administrative efficiency.

Some skilled nursing facility operators have used the increased funding to improve care and staffing; many others have not.

Key indicators suggest that the quality of care has declined, not improved, since AB 1629 was enacted. For example:

- Public complaints to DPH rose from 8,694 in 2004 to 13,691 in 2007, a 57 percent increase.³
- The number of complaint allegations that DPH substantiated expanded from 1,493 in 2004 to 2,638 in 2007, a 76 percent increase.⁴
- The number of facility reported incidents received by DPH rose from 7,438 in 2004 to 13,207 in 2007, a 77 percent increase.⁵
- The number of facility reported allegations to DPH related to resident abuse more than doubled from 1,839 in 2004 to 4,542 in 2007.⁶
- The number of facility reported allegations that DPH substantiated more than tripled from 931 in 2004 to 3,284 in 2007.⁷
- Findings of immediate jeopardy, actual harm and substandard quality of care grew from 551 in 2004 to 845 in 2007, a 53 percent increase.⁸
- The number of citations DPH issued to skilled nursing facilities rose from 471 in 2004 to 698 in 2007, a 48 percent increase.⁹
- The number of AA citations for violations that directly led to a resident's death more than doubled from 11 in 2004 to 23 in 2007.¹⁰
- In December 2008, the federal Centers for Medicare and Medicaid Services (CMS) rated 551 California nursing facilities (44%) as being much below average or below average based on inspection findings, staffing levels and quality measures.¹¹

To achieve its objectives, AB 1629 must be reformed to ensure that Medi-Cal spending is directed to care, services and staffing that directly benefit skilled nursing facility residents. This is especially urgent in the budget crisis. The following recommendations serve that purpose.

A. The Legislature should redirect spending and strengthen incentives to improve care and staffing through the following recommendations:

1. 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.¹² Additionally, Medi-Cal projects that the labor driven operating allocation will cost it about \$180 million during FY 08-09.¹³ 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.

2. 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.

3. 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,¹⁴ 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.¹⁵ 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.

4. 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.¹⁶ These guidelines are insufficient because they do not address legal fees related to inspection and investigation findings.

5. 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.¹⁷ They state that the 50th percentile cap on the administration cost component is relied upon for cost control.¹⁸ 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.¹⁹ OSHPD reports that operating margins and operator returns on assets have also risen steeply since AB 1629 was enacted.²⁰ 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.

B. The Legislature should take the following actions to improve skilled nursing facility staffing:

- 1. 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, Statutes 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.²¹ 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 2007,²² 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.²³ The proposal to require at least 1.0 hprd by licensed nurses is slightly less than current average nurse staffing levels²⁴ 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.²⁵

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 2007,²⁶ less than half of the recommended 0.75 hprd. California skilled nursing facilities have not improved RN staffing since AB 1629 was implemented.²⁷ 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.

2. 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.²⁸ 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 \$1,000.²⁹ 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 06-07.³⁰ 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 06-07,³¹ 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.³²

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.

3. 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.³³ Adjusted for inflation, CNA wages actually decreased during this same period.³⁴

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.

4. 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 2007.³⁵ Turnover rates for licensed nurses declined from 57.98 percent in 2004 to 53.84 in 2007.³⁶

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.³⁷ 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.

C. 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.

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

1. Requiring 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.³⁸ This oversight should be corrected so that Medi-Cal can determine when corporations are diverting funds intended for care.

2. 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.³⁹ This oversight should be corrected.

3. 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.⁴⁰ 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.⁴¹

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

4. 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.⁴²

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.⁴³ 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.

5. Requiring 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."⁴⁴ 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.

6. 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.

7. Establishing clear definitions and providing clarification on problematic terminology.

The Audits and Investigation Division reports that AB 1629 contains certain ambiguities and vagueness that has created challenges and additional time demands.⁴⁵ It believes that

concrete definitions and additional clarification in these areas would resolve misunderstandings and alleviate the current volume of correspondence between providers, auditors, policy and appeals.

The Department should identify the needed changes and the Legislature should address them.

8. 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."⁴⁶ It reports that unknown consequences to the general fund have occurred due to this shortcoming of the system.

The Legislature should correct this problem.

E. The Legislature should take the following actions to bring California into compliance with the Supreme Court's *Olmstead* decision

One of the purposes of AB 1629 is to ensure access to "appropriate long term care services." Institutional long term care (e.g. nursing home care) is not appropriate for anyone who wants to and can be supported to live in a less restrictive and more integrated setting. Further, the 1999 US Supreme Court *Olmstead* decision affirmed that unnecessary institutionalization is illegal, in violation of the integration mandate of the Americans with Disabilities Act of 1990. Ten years after *Olmstead*, California continues to deny many nursing home residents and others needing long term care consumers a real choice to receive care at home or another community based setting.

Key indicators of this problem include:

1. Unlike other states, California does not have a program to divert people who can be served at home or in community settings from nursing homes. So-called pre-admission screening is done post-admission, with no timely opportunity for consumers to access alternatives.
2. In contrast to other states, California has only a miniscule state-financed program to help transition residents from nursing homes, despite evidence that at least a third of residents would like to leave, and that residents of any age, level of need and length of stay can live in the community.
3. Medicaid allows skilled nursing facility residents with a share of cost to keep a Home Upkeep Allowance (HUA) for up to six months to retain a home in the community if a physician says the resident is likely to return home. However, California limits the HUA to \$209 per month, a totally inadequate amount. There is overwhelming evidence that lack of affordable housing is a major barrier to residents transitioning from nursing homes to the community.
4. Nursing homes face no consequences for failing to arrange transition services for residents who have expressed a desire to return home.

5. California nursing home residents and others needing long term care are not equally entitled to alternatives to nursing home care. For example, Medi-Cal has only 1,200 nursing facility waiver slots, a cap of 283 hours per month of IHSS, very limited coverage for assisted living, and no other modes such as adult family homes or supported living.
6. The Governor is proposing severe cuts to nursing home alternatives, such as the In Home Supportive Services (IHSS) program and Supplemental Security Income (SSI) and has already cut Multipurpose Senior Services Program (MSSP), and Adult Day Health Care services. The Governor is also proposing to eliminate eight Medi-Cal “optional benefits.” The medical services proposed for elimination would still be provided to Medi-Cal beneficiaries in a nursing home.
7. California's waiver programs use a formula that provides much less funding per consumer than would be spent by the state for the same consumer on nursing home care.
8. California's long term care budget is segregated into institutional and home-and-community-based portions, unlike other states that recognize that the same population is served in both settings.
9. California has no system to reduce Medi-Cal nursing home expenditures by reducing excess skilled nursing facility capacity.

The following short-term and longer-term recommendations address these concerns:

Short-term recommendations:

1. 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:

- 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.⁴⁷ 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.
- f. In addition to the MDS, the state should require use of other tools that have been created to identify a resident's interest in returning home and the suitability of the transition.

On a longer-term basis, the state should:

1. **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.**

For example, Washington has reduced state spending on the cost of maintaining empty nursing home beds, reduced the number of nursing home beds, and adopted universal budgeting for long term care.

- 2. Identify goals for California's long term care system that eliminate incentives for institutionalization and establish meaningful choices for consumers.**
- 3. Explore whether California can save money by procuring more Medicare funds for nursing home stays, as Connecticut has done.**

¹ The average Medi-Cal rate for a freestanding skilled nursing facility has increased from \$118.06 in FY 03-04 to \$161.81 in FY 08-09.

² DHCS handout to workgroup on the quality assurance fee.

³ DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 30. It is likely that the figures in this report represent the number of complaint allegations rather than the number of complaints. In a separate document provided to the workgroup, DPH reports that public complaints grew from 4,920 in 2004 to 5,593 in 2007, an 11 percent increase.

⁴ Attachment I, DPH handout provided at the December 17, 2008 workgroup meeting.

⁵ Attachment I, DPH handout provided at the December 17, 2008 workgroup meeting.

⁶ Attachment I, DPH handout provided at the December 17, 2008 workgroup meeting.

⁷ Attachment I, DPH handout provided at the December 17, 2008 workgroup meeting.

⁸ DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 35.

⁹ DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 31.

¹⁰ DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 30.

¹¹ Nursing Home Compare, www.medicare.gov.

¹² 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.

¹³ 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.

¹⁴ DHCS handout on Professional Liability Insurance distributed at the December 1, 2008 workgroup meeting.

¹⁵ 2007.08 Final Rates, DHCS website at: <http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx>

¹⁶ Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 2.

¹⁷ Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.

¹⁸ Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.

¹⁹ 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.

²⁰ OSHPD handout, December 17, 2008.

²¹ 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.

²² OSHPD handout, December 17, 2008.

²³ 22 CCR §72329.

²⁴ 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).

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- ²⁵ 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.
- ²⁶ OSHPD handout, December 17, 2008.
- ²⁷ 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.
- ²⁸ 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.
- ²⁹ DPH handout to workgroup.
- ³⁰ DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 13.
- ³¹ DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 18.
- ³² OSHPD handout, December 17, 2008.
- ³³ DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, page 21.
- ³⁴ 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.
- ³⁵ OSHPD handout, December 17, 2008.
- ³⁶ OSHPD handout, December 17, 2008.
- ³⁷ DPH January 1, 2009 Report to the Legislature, AB 1629 Impact Report, pages 24-27.
- ³⁸ Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.
- ³⁹ Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.
- ⁴⁰ *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.
- ⁴¹ *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.
- ⁴² Welfare & Institutions Code §14126.023(h).
- ⁴³ December 30, 2008 e-mail to workgroup members from Barbara Bailey, Chief, Medi-Cal Benefits, Waiver Analysis and Rates Division.
- ⁴⁴ Audits and Investigations Response to Workgroup Questions, December 1, 2008, pages 1-2.
- ⁴⁵ Audits and Investigations Response to Workgroup Questions, December 1, 2008, page 3.
- ⁴⁶ Audits and Investigations handout, How Do We Know if the Audit System is Working, November 26, 2008.
- ⁴⁷ 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)."