

Skilled Nursing Facility  
Quality Assurance (AB 1629) Workgroup  
Legislative Report

Prepared by  
Department of Health Care Services  
Medi-Cal Benefits, Waiver Analysis and Rates  
Division – As Required by Section 14126.034 of the  
Welfare and Institutions Code

April 2009

Department of Health Care Services  
Medi-Cal Benefits, Waiver Analysis and Rates Division

Skilled Nursing Facility Quality Assurance (AB 1629) Workgroup Legislative  
Report

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## EXECUTIVE SUMMARY

The Health Budget Trailer Bill of 2008 (Assembly Bill (AB) 1183) formalized the stakeholder feedback process regarding the rate-setting methodology established under AB 1629 (Chapter 875, statutes of 2004) by establishing a workgroup comprised of 18 interested stakeholders representing consumers/advocates, skilled nursing facility labor, and skilled nursing facilities, together with representatives from the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Office of Statewide Health Planning and Development, and the Office of the State Long-Term Care Ombudsman. The AB 1629 Workgroup (workgroup) was required to review and recommend changes to the AB 1629 rate-setting methodology, which would lead to improvements in the quality of care provided at SNFs. The workgroup met seven times from November 2008 through January 2009, and the attached AB 1629 Workgroup Summary Report (summary report) contains a complete account of the workgroup process.

More than 60 recommendations were submitted by the workgroup members and the public. The enabling legislation for the workgroup did not set parameters regarding the number or nature of the recommendations that could be submitted. However, three themes surfaced during the workgroup process as principal discussion items – quality and the definition of quality indicators, pay-for-performance (P4P), and data collection and reporting. The workgroup discussions and the various recommendations highlight an overarching need to have a more patient centered care approach that would help providers improve care for their patients, improve clinical decision making, improve care transitions, care coordination and continuity of care. Despite common ground on the goal to improve care quality and the measurement of quality, participants maintained different perspectives with regard to the specific recommendations, as well as how best to implement change in the area. Reaching consensus on specific measures or recommendations was difficult and was unresolved by the conclusion of the workgroup.

The summary report contains all recommendations submitted by the workgroup and the public, as well as supporting information offered by recommenders and a voting record for each recommendation. Below are several of the recommendations with a brief discussion as to why the implementation of each is or is not feasible.

- ***Immediate implementation of 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; raise the minimum 3.2 standard to 3.5 hours per patient day, as outlined in AB 1075, and map out how to progress toward the 4.1 minimum standard recommended by the National Citizen's Coalition for Nursing Home Reform (NCCNHR) and many researchers and advocates; and implement the staffing ratios without waiting for a specific state appropriation for that purpose.***

While increasing the staff-to-patient ratios could promote a higher quality of care, increasing the ratios would also have a large annual fiscal impact, and likely also result in increases in the per-diem rates charged to private-pay patients.

Increasing the minimum staffing ratios may not have the intended result of increasing the quality of care, due to the current shortage of nurses.

Regarding the immediate implementation of the staffing ratio regulations required by Health and Safety Code Section 1276.65, these regulations can not become operational until an appropriation is provided in accordance with the statute.

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

This recommendation is highly problematic for several reasons. If implemented, this recommendation would require additional annual increases to the rates well beyond what is determined under the current rate-setting methodology, since caregiver wages and benefits are the largest component of facility spending. In addition, confirmation of the rate increases would be necessary, which would require additional audit staffing. For those providers who did provide the wage increase, a retroactive adjustment of their rates would be necessary, which would also be costly from an administrative standpoint.

- ***The state should do more to enable community living by establishing statewide nursing home transition programs: strengthening requirements for discharge planning and hospital-to-home transitional care services; expanding our current home and community-based services (HCBS) waiver slots to provide more choices to individuals; and expanding the number of the state's existing Aging and Disability Resource Centers to provide statewide coverage so that every Californian has easy access to information, counseling and program linkage on aging and long-term care support options.***

This recommendation could be accomplished through enhanced partnerships (1) between the State and stakeholders and (2) among local community stakeholders/partners. Many stakeholders are active in two existing projects – California Community Transitions and California Community Choices – both of which seek to build long-term services and supports infrastructures at the local level. In order to accomplish this objective, both projects, which are limited in scope, depend on a high degree of coordination among local community service partners, as well as nursing facilities, the California Health and Human Services Agency and various State departments. Also, the Nursing Facility/Acute Hospital waiver is expanded annually per Senate Bill 643 (Chesbro, Statutes of 2005, Chapter 551), and the Developmentally Disabled waiver increases the number of enrollees annually as well. While the recommendation basically relies on entities and vehicles outside a skilled nursing facility for implementation, nursing facilities play a key role in the success of transition efforts. In October 2010, CMS will implement the Minimum Data Set 3.0, including the question in Section Q: "Do you want to speak to someone about returning to living in the community?" This question will prompt nursing facilities to work with community partners to facilitate transitions to community settings. This recommendation is consistent with the need to prepare for Section Q implementation.

- ***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.***

Measuring resident, family, and staff satisfaction on a uniform basis is a worthwhile and a good indicator of quality (or a lack thereof). While funding is not currently available to pay for the State to develop a uniform data collection system, DHCS is actively evaluating the use of existing systems, such as the federal Minimum Data Set and 5-Star Facility Rating System for such purposes. DHCS is supportive of adding satisfaction levels and satisfaction improvement rates as publicly reported measures in California.

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

While this recommendation does not have a direct correlation with improving the quality of care, lowering reimbursements for liability insurance would provide facilities with an incentive to undertake efforts to increase facility safety and make improvements in other areas that would result in the filing of fewer claims. The recommendation could also provide an incentive for self-insured facilities to further control the costs of their self-insurance programs. The savings that would result from implementing the recommendation could be used to provide quality improvement enhancements to the rate-setting methodology.

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

Incentivizing investment in health information technology aligns with both federal and state goals to improve care quality and efficiency and reduce costs through the use of health information technology. If this recommendation were implemented, quality measures should be developed and implemented concurrently so that the impacts on quality could be assessed and providers reimbursed appropriately. Although a redistribution of spending might occur among facilities that increased spending for pass-through items that would be covered under the recommendation, the benefits of increased health information technology utilization from a health care quality and patient experience perspective could outweigh the costs of a spending redistribution.

- ***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.***

This recommendation may duplicate existing committees that facilities have organized for addressing quality and staffing issues. (Such types of committees are already required by state and federal regulations.) This recommendation may also not be feasible from the standpoint of the oversight and monitoring that would be necessary to ensure that rate enhancements were only provided in those cases where the existence of the committees were resulting in tangible improvements in the quality of care and a proper vetting of staffing issues. A

more effective approach for enhancing facility quality and increasing staffing retention levels is to provide incentives on a system-wide basis using uniform quality measures.

- ***The state's website should include more information about facility citations and deficiencies, including copies of the citations themselves. In addition, the ratesetting methodology will work best when it is balanced with an appropriate enforcement scheme. Penalty amounts have not been increased in eight years. The penalty for "AA," "A" and "B" citations should all be increased.***

The CDPH website can be modified to include additional information about facility citations, beginning with the posting of the AA citations. The posting of this additional information could provide for increased consumer awareness and empower consumers and their families to make more informed decisions about selecting long-term care facilities. A more effective alternative to increasing the penalty amounts for "AA," "A" and "B" citations would be to incorporate into the rate-setting methodology incentives based on performance outcomes and practices tied to uniform quality measures.

The recommendations illustrate substantial agreement among diverse stakeholder groups on broad issue areas that should be addressed, as well as the significant differences in stakeholders' beliefs about the appropriate strategies for addressing these issues. This dichotomy may arise from differences in stakeholders' definitions of quality, views on how to report quality, and favored strategies to incentivize quality improvement, as highlighted on pages six and seven of the summary report. These differences characterized the workgroup's discussion of implementing a P4P system within AB 1629. While the debate on P4P was tabled early in the workgroup process, P4P supporters felt that several recommendations were, in fact, based on the principles of P4P though they were submitted by P4P opponents. Workgroup members acknowledged that differing definitions contributed to this problem.

While significant differences remain in stakeholders' beliefs about the appropriate strategies for addressing the issue of quality, DHCS believes that the fundamental approach to improving quality of care and health outcomes of nursing facility residents is to develop payment mechanisms that reward individual facilities for providing high quality care. The AB 1629 reimbursement system can be adapted to tie reimbursement to high performance in terms of SNF staffing, resident outcomes, resident and staff experience, community transitions, and other important quality measures. DHCS believes it can use existing quality measures, collected by the Centers for Medicare and Medicaid Services, to immediately implement P4P into AB 1629-affected facility rates. However, these quality measures alone are insufficient and will need to be supplemented in years to come with additional measures of care quality and improving patient (and staff) experience. The goal will be to work with stakeholders to develop an array of quality measures that is more expansive and reliable to ensure that the AB 1629 payment system is identifying all factors that lead to providing high quality care.

The development of these measures will also allow consumers and family members to have more reliable information to help them make informed health care choices.

DHCS thanks the members of the AB 1629 Workgroup for their active participation, especially in light of the short timeframe they had to review and understand the nuances of the reimbursement system and develop substantive recommendations for its improvement. Despite differences in perspectives and recommendations, all workgroup members demonstrated a strong commitment to high quality care for SNF residents. DHCS also thanks the California HealthCare Foundation for the funding that supported the workgroup process and Monique Parrish, DrPh, MPH, LCSW, for her able facilitation of the workgroup and development of the summary report.

## Introduction and Background

### Skilled Nursing Facility Quality Assurance (AB 1629) Legislative Report

California changed its skilled nursing facility (SNF) Medicaid reimbursement methodology following passage of the Medi-Cal Long Term Care Reimbursement Act of 2004, Assembly Bill (AB) 1629. The Health Trailer Bill of 2008, AB 1183, formalized the stakeholder feedback process regarding the rate-setting methodology established under AB 1629 by establishing a workgroup comprised of 18 interested stakeholders representing consumers/advocates, labor and SNFs, together with representatives from the California Department of Health Care Services (DHCS), the California Department of Public Health, the Office of Statewide Health Planning and Development, and the Office of the State Long-Term Care Ombudsman. The workgroup was tasked with making recommendations to DHCS for a reimbursement methodology that ensured compliance with the intent of AB 1629, primarily regarding improvements in the area of quality of care provided at SNFs. The enabling legislation for the workgroup did not include parameters regarding the number or nature of the recommendations that could be submitted.

This report addresses the outcome of the workgroup. Specifically, Welfare and Institutions Code Section 14126.034 mandates that the DHCS... “shall review and analyze all recommendations from the stakeholder workgroup, individual workgroup members, and any other interested stakeholders, and no later than March 2009, the department shall deliver to the Legislature, both of the following:

- (1) The complete recommendations of the stakeholder workgroup, individual workgroup members, and any other interested stakeholders.
- (2) The department’s analysis of the feasibility to implement the proposed recommendations.”

The workgroup met seven times between November 2008, and January 2009. Sixty-six recommendations were submitted by the 18 voting workgroup members and the public. (For a detailed discussion regarding the workgroup meetings, please see the enclosed AB 1629 Workgroup Summary Report.) DHCS has prepared an analysis of the feasibility of implementing each of the recommendations in the following section, entitled “AB 1629 Workgroup Recommendations Analysis.” While few recommendations contain the specificity needed to develop a refined rate-setting methodology, DHCS believes that there

is underlying support among workgroup members for payment mechanisms that reward individual facilities for providing high quality care. The AB 1629 reimbursement system can be adapted to tie reimbursement to high performance in terms of SNF staffing, resident outcomes, satisfaction, community transitions, and other important quality measures.

DHCS supports continued discussions with stakeholders and the Legislature regarding the definition of quality and ways in which a reimbursement mechanism can provide a meaningful financial reward for high quality of service. In the absence of more developed recommendation proposals at this time, DHCS is also encouraged to continue efforts to improve the timeliness of AB 1629 monitoring, data collection and reporting.

The fiscal impact of the report's recommendations is undetermined at this time, as the workgroup provided no specific methodology for evaluation. Also, several recommendations are outside the workgroup's principal mandated charge of developing recommendations for revising the AB 1629 rate-setting methodology to further enhance the quality of care for nursing home residents. In those cases where the recommendation includes sufficient detail for evaluation and appears to have a direct correlation with improving quality, additional research and study will be necessary in order to determine the fiscal impact.

## AB 1629 Workgroup Recommendations Analyses

## AB 1629 Workgroup Recommendations Analyses

Recommendation: A.1.i Improve and update the current Medi-Cal free-standing skilled nursing facility cost reporting methodology.		
YEA: 18	NAY: 0	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• Eliminates the need for ongoing supplemental reporting.</li> <li>• Improves transparency in the cost reporting process by specifically identifying certain costs currently reported in broad cost categories.</li> <li>• Has the potential to improve efficiency in the audit and rate setting process.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• Requires DHCS and OSHPD to develop and implement a new cost report or to augment the current reporting process.</li> <li>• The current provider Medi-Cal cost reporting would change.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care. In addition, the recommendation appears to be unnecessary. The Office of Statewide Health Planning and Development (OSHPD) has already developed and will soon be utilizing a revised format for the cost report (Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report), which eliminates the need for supplemental reports and provides more transparency in the cost reporting process. DHCS issued a Medi-Cal Provider Bulletin regarding the revised cost report format on March 15, 2009.</p>		

Recommendation: A.1.ii. Require facility cost reports to specifically capture management fees to corporate offices and other corporate office costs.		
YEA: 12	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• More transparency in this area would enable Medi-Cal to determine when corporations are diverting funds intended for care.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• This recommendation is largely duplicative of reporting requirements currently in place.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care. Although management fees are required to be identified on page 3.1 of the current OSHPD cost report, this recommendation has merit as it could provide for the reporting of additional management fee cost items. DHCS welcomes stakeholder input as to what specific additional management fee cost items would provide increased transparency and other benefits.</p>		

Recommendation: A.1.iii. Require cost reports to be synchronized with the AB 1629 rate system.		
YEA: 12	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• The cost reports would match the current rate system, as opposed to the rate system replaced by AB 1629.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• This recommendation has already been addressed by changes to the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care. In addition, the recommendation appears to be unnecessary.</p> <p>Cost reports will be synchronized with the AB 1629 rate system through the revised Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report, which will be implemented by OSHPD in the near future.</p>		

## AB 1629 Workgroup Recommendations Analyses

Recommendation: A.1.iv. Redesign the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report.		
YEA: 12	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• The report could be redesigned in consultation with interested stakeholders so that it would collect additional relevant information that could assist with the rate-setting process.</li> <li>• The additional information collected could improve the analysis of the impact of the Medi-Cal reimbursement system.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• Implementation of this recommendation would require upgrades to OSHPD's mainframe platform and the hiring of additional audit staff, which could increase OSHPD's Facility Data Fee.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>While implementation of the recommendation is feasible, these additional reporting requirements would increase the number of items reported to OSHPD beyond what has been incorporated into the new cost report format. Due to initial design constraints of OSHPD's mainframe platform, the report would need to be migrated to a newer (current technology) platform. After this update, more audit staff (one or two positions) would be required to audit the additional data. In order to accommodate these increased costs, OSHPD's Facility Data Fee rate might need to be increased, which in turn would require a statutory change (Health &amp; Safety Code, Section 127280).</p>		

Recommendation: A.2.i. Shorten the lag time between facility expenditures and Medi-Cal reimbursement rate adjustments.		
YEA: 0	NAY: 18	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• Implementation of this recommendation would enable facilities to more quickly recover the costs incurred in facility operations.</li> <li>• Shortening the lag times could encourage facilities to commit to new spending, which in turn could improve the quality of care.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• DHCS would have to hire additional staff to accommodate the additional workload that could occur under the methodology necessary to implement this recommendation.</li> <li>• With respect to facility labor expenditures, this recommendation could be duplicative of the system that CMS is establishing to collect payroll data.</li> </ul>	
<p>DHCS Analysis: In order to implement this recommendation, the methodology would most likely have to incorporate a retrospective settlement whereby a tentative rate would be set based on current costs. An adjustment to the rate paid per day based on audit results would then be retroactively applied to the routine costs claimed during that period and a settlement would be included in the provider's statement of account status. This methodology would be similar to the acute settlements performed on noncontract hospitals participating in the Medi-Cal program. This change would increase the workload of DHCS' Long-Term Care Systems Development Unit, which sets the rates using the methodology mandated under AB 1629, as rates would have to be set twice and the settlement process employed. It should be noted that any change to the current rate-setting methodology would require approval of a SPA from CMS, and would likely entail a time span of one year or more. DHCS sees merit in utilizing more current cost data in the setting of facility rates and will continue to work with stakeholders to explore options that would be workable for both facilities and the state.</p>		

## AB 1629 Workgroup Recommendations Analyses

Recommendation: A.2.ii. Advance timing for cost recognition when determining annual AB 1629 facility-specific rates.		
YEA: 12	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• Providers would not be subject to the current 18-24 month delay in being reimbursed for costs incurred.</li> <li>• Implementation could mitigate provider impediments to advancing costs for increased staffing, improving workforce wages and benefits, and improving facility infrastructure.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• This recommendation would advance the time frames for state agencies and providers to ensure cost reporting, receipt and review (of data), and audits are timely and up to date, which in turn could result in additional staffing needs.</li> <li>• Implementation could require that the current rate-setting methodology be revised and a change to the Health &amp; Safety Code.</li> <li>• With respect to facility labor expenditures, this recommendation could be duplicative of the system that CMS is establishing to collect payroll data.</li> </ul>	
<p>DHCS Analysis: This recommendation appears to duplicate Recommendation A.2.i. If the implementation of this recommendation were to entail more than expedited cost reporting to OSHPD, the rate-setting methodology would likely have to incorporate a retrospective settlement whereby a tentative rate would be set based on current costs. (Please see the analysis under Recommendation A.2.i.) If implementation of this recommendation were to entail a change in due dates for any of the data reported to OSHPD, a change to Health &amp; Safety Code, Section 128755, would be necessary. Implementation of this recommendation would also likely require additional staffing in the DHCS' Long-Term Care Systems Development Unit, which sets the rates using the methodology mandated under AB 1629. DHCS sees merit in utilizing more current cost data in the setting of facility rates and will continue to work with stakeholders to explore options that would be workable for both facilities and the state.</p>		

Recommendation: A.2.iii. Address the time lag of facilities increasing costs and recognition of these costs in Medi-Cal reimbursement rates.		
YEA: 18	NAY: 0	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• This recommendation would expedite the recognition of facility costs in their Medi-Cal rates.</li> <li>• The expedited cost recognition could encourage facilities to increase expenditures, which in turn could result in quality improvements.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• OSHPD might have to develop a new system and establish additional positions.</li> <li>• The current rate-setting methodology might require revisions.</li> <li>• Additional positions might have to be established within DHCS.</li> <li>• With respect to facility labor expenditures, this recommendation could be duplicative of the system that CMS is establishing to collect payroll data.</li> </ul>	
<p>DHCS Analysis: This recommendation appears to duplicate Recommendations A.2.i and A.2.ii. The supporting information provided by the party that submitted the recommendation indicates that it relates to the reporting of payroll data. If OSHPD were tasked with the collection of the payroll data, a new system would need to be developed and additional positions established, based on the Feasibility Study Report that would have to be drafted. In order to accommodate the related increased costs, OSHPD's Facility Data Fee rate might have to be increased, which in turn would require a statutory change (Health &amp; Safety Code, Section 127280). Implementation of this recommendation would also likely require that the current rate-setting methodology incorporate a retrospective settlement whereby a tentative rate would be set based on current costs, as detailed in the analysis of recommendation A.2.i. This change in turn would require approval of a SPA from CMS. This recommendation would have been stronger if it specified the exact data that would be reported and to whom the data would be reported. DHCS will continue to work with stakeholders to explore options for utilizing more current cost data in the setting of facility rates that would be workable for both facilities and the state.</p>		

## AB 1629 Workgroup Recommendations Analyses

<p>Recommendation: A.3.i. 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 (CDPH) 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.</p>		
YEA: 6	NAY: 5	ABSTENTION: 7
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• This recommendation has the potential to provide for improved quality of care and lowering facility staff turnover levels through increased training.</li> <li>• The recommendation could lead to the development of standards and requirements to ensure that staff training is effective.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• No standards or requirements have been included to ensure the appropriateness and effectiveness of the training.</li> </ul>	
<p>DHCS Analysis: This recommendation is feasible and relevant to enhancing the quality of care provided in nursing homes. However, including in the 100 percent pass-through all training directly related to the quality of care should be implemented in conjunction with the establishment of associated standards and requirements to ensure the appropriateness and effectiveness of the training. This recommendation would result in a rate methodology change that would require CMS approval of a SPA. This is often a lengthy process to complete.</p> <p>CDPH would require additional resources to accommodate the additional workload that would be associated with an annual review of survey and Quality Measure data for the purpose of identifying and recommending priority-training topics for skilled nursing staff. DHCS and CDPH agree that it would be more effective for each facility to design training for their own staff, based on their Minimum Data Set data reports and surveys.</p>		

<p>Recommendation: A.3.ii. 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 supports opportunities for employee advancement, RN and LVN training, and dietary training – also to include cultural, linguistic, and disability competency training.</p>		
YEA: 12	NAY: 6	ABSTENTION: 0
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• This recommendation has the potential to provide for improved quality of care and lowering facility staff turnover levels through increased training.</li> <li>• The recommendation could lead to the development of standards and requirements to ensure that staff training is effective.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• Conducting the assessment or study required under this recommendation could be costly.</li> </ul>	
<p>DHCS Analysis: It is likely that additional and enhanced staff training that is subject to standards and requirements will ensure that the training is effective in improving and maintaining quality of care, as well as in reducing staff turnover levels. DHCS staff and interested stakeholders could work together to develop a facility survey instrument that would be issued to all facilities for soliciting feedback as to why training funded through the pass-through is not being utilized to a greater extent. This survey could also request input regarding additional funding for staff training.</p>		

## AB 1629 Workgroup Recommendations Analyses

Recommendation: A.4.i. Require skilled nursing facilities to report staffing information from payroll records on a quarterly basis.		
YEA: 12	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>This recommendation has the potential to make facility staffing information more current and transparent.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>The recommendation could also be duplicative of the payroll-based staffing reporting system being developed by CMS.</li> </ul>	
<p>DHCS Analysis: The supporting information provided by the party that submitted the recommendation indicates that its purpose is to provide a means for assessing the impact of the rate-setting methodology on facility staffing levels. The use of self-reported data could be problematic from the standpoint of the data being inaccurate or incomplete. This recommendation might be premature relative to the payroll-based staffing report system being developed by CMS.</p> <p>This recommendation would have been stronger if it had specified the exact data that would be reported and to whom the data would be reported.</p>		

Recommendation: A.4.ii. The state should require payroll data reporting for purposes of enforcement of staffing requirements and more updated labor cost reporting into the rate system.		
YEA: 12	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>This recommendation would make facility staffing data more current.</li> <li>The use of more current staffing data in the rate-setting process could encourage providers to spend more on labor, which could in turn enhance quality.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>Just using more current labor cost data would result in a mismatching of cost components within the rate-setting methodology for different time periods.</li> <li>The recommendation could be duplicative of the payroll-based staffing reporting system being developed by CMS.</li> <li>The payroll data reported would apparently be self-reported and thus unaudited.</li> </ul>	
<p>DHCS Analysis: This recommendation appears to rely on the use of self-reported payroll data, which has a higher potential for being inaccurate or incomplete compared to audited data. Labor cost is the largest cost component; therefore, utilizing audited cost data in determining labor reimbursement levels is critical. Integration of the more current labor cost data into the rate-setting methodology would also result in a mismatching of labor costs with the other cost components. Nonetheless, DHCS sees merit in utilizing more current cost data in the setting of facility rates and will continue to work with stakeholders to explore options that would be workable for both facilities and the state. Although the rates under the AB 1629 methodology are reset each year, the cost data employed, including that for labor costs, is approximately two years old. CDPH is in favor of the use of required payroll data for the purpose of assisting with the enforcement of staffing standards.</p>		

Recommendation: A.5.i. Create a new state minimum staffing standard for registered nurses (RN) in skilled nursing facilities – we recommend a .32 hour pp/pd standard for RNs.		
YEA: 0	NAY: 11	ABSTENTION: 7
<b>PRO:</b> <ul style="list-style-type: none"> <li>This recommendation could improve the quality of care.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>This recommendation could institutionalize RN Staffing levels in skilled nursing facilities, which in turn could discourage facilities from using a higher staffing standard for RNs.</li> <li>Implementing the recommendation would require CDHP to establish regulations and compliance procedures.</li> </ul>	
<p>DHCS Analysis: This recommendation does not provide the documentation necessary to support why .32 pp/pd is an appropriate standard for RNs, or how this change would enhance quality of care. CDPH will need to research this issue prior to considering any changes. Changes in minimum nursing standards would require amendments to the California Code of Regulations, Title 22 and in statute.</p>		

## AB 1629 Workgroup Recommendations Analyses

<p>Recommendation: A.5.ii. 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.</p>		
YEA: 6	NAY: 6	ABSTENTION: 6
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• The additional direct care staff could improve the quality of care.</li> <li>• The minimum staffing requirements for licensed nurses could improve the quality of care.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• The additional annual cost to implement a 3.5 standard would have a large fiscal impact.</li> </ul>	
<p>DHCS Analysis: While increasing the minimum staffing requirements could promote a higher quality of care, increasing the ratio will also increase the fiscal demand on the State, and would likely also result in increases in the per-diem rates charged to private-pay patients. Increasing the minimum staffing requirements may not have the intended result of increasing quality of care, due to the current nursing shortage. In order to more effectively assess improvements in quality of care, any increases in the staff-to-patient ratio should also be coupled with the development and implementation of quality measures.</p> <p>This recommendation is contained in current legislation, AB 1038 (Furutani), with respect to raising the minimum staffing requirements from 3.2 to 3.5 hours per resident day. Both DHCS and CDPH will keep watch on the outcome of this legislation.</p>		

<p>Recommendation: A.5.iii. 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 the National Citizen's Coalition for Nursing Home Reform (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.</p>		
YEA: 12	NAY: 6	ABSTENTION: 0
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• More direct care staff could promote better care.</li> <li>• The NCCNHR and researchers recommend a minimum of 4.1 NHPPD.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• The additional cost to implement either a 3.5 or 4.1 standard would have a large annual fiscal impact.</li> </ul>	
<p>DHCS Analysis: While increasing the staff-to-patient ratios could promote a higher quality of care, increasing the ratios would also increase the fiscal demands on the State, and likely also result in increases in the per-diem rates charged to private-pay patients. Increasing the minimum staffing ratios may not have the intended result of increasing the quality of care, due to the current shortage of nurses. In order to more effectively assess improvements in the quality of care, any increases in the ratios should be implemented in conjunction with the development and implementation of quality measures.</p> <p>Regarding the immediate implementation of the staffing ratio regulations required by Health &amp; Safety Code Section 1276.65, these regulations can not become operational until there is an appropriation in accordance with the statute. Current legislation, AB 1038 (Furutani), proposes raising the 3.2 standard to 3.5 hours. Both DHCS and CDPH will keep watch on the outcome of this legislation.</p>		

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<p>Recommendation: A.6.i. Adjust for costs associated with the reimbursement methodology and reporting requirements transitioning patients to community based care. (This recommendation further requires that DHCS establish a stakeholder group to help identify facility costs associated with transitioning patients to community-based care and to establish a level of cost reimbursement at the 95<sup>th</sup> percentile for these activities.)</p>		
YEA: 0	NAY: 11	ABSTENTION: 7
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• This recommendation would make the facility costs associated with transitioning patients to community-based care more transparent.</li> <li>• Establishing a level of reimbursement at the 95<sup>th</sup> percentile for facilities within a peer group for transition activities could result in more community placements.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• DHCS would incur a minor workload increase resulting from additional audit steps.</li> <li>• Increasing the level of reimbursement for transitioning activities at the 95<sup>th</sup> percentile could redirect spending from current facility quality of care improvement efforts.</li> </ul>	
<p>DHCS Analysis: DHCS is supportive of efforts that would further identify facility costs that would be associated with transitioning patients to community-based care. While DHCS would welcome input from stakeholders in identifying such costs, DHCS believes that these costs could be identified without the formation of a stakeholder group. DHCS is not opposed to increasing reimbursements for transitioning efforts, but believes that the increased reimbursements should be implemented in conjunction with standards and protocols that would ensure the success of such efforts. Additional workload would likely be limited to additional audit steps which would have to be performed by the DHCS' Audits &amp; Investigations program auditors. CMS approval of a SPA would likely be necessary. Implementing this recommendation would also require the minimal OSHPD effort of adding one line item to the cost report.</p>		

<p>Recommendation: A.6.ii. Due to the budget crisis, the legislature should freeze total Medi-Cal spending on skilled nursing facilities at current levels, and use the General Fund savings to address short- and long-term recommendations that bring California into compliance with the Supreme Court's Olmstead decision.</p>		
YEA: 5	NAY: 13	ABSTENTION: 0
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• More funding would be available for Olmstead-related efforts.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• Freezing reimbursements would likely cause some facilities to close and the quality of care to decline at others.</li> </ul>	
<p>DHCS Analysis: While this recommendation meets the spirit and intent of the Olmstead decision, freezing total Medi-Cal spending on skilled nursing facilities in order to bring California into compliance with Olmstead could result in some facility closures and spending decreases among others. These spending decreases could in turn adversely impact quality.</p>		

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<p>Recommendation: A.6.iii. The state should do more to enable community living by establishing statewide nursing home transition programs; strengthening requirements for discharge planning and hospital-to-home transitional care services; expanding our current home and community-based services (HCBS) waiver slots to provide more choices to individuals; and expanding the number of the state's existing Aging and Disability Resource Centers to provide statewide coverage so that every Californian has easy access to information, counseling and program linkage on aging and long-term care support options.</p>		
YEA: 12	NAY: 0	ABSTENTION: 6
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• This recommendation has the potential for transitioning a larger number of nursing home residents into the community.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• This recommendation may be duplicative of existing programs and resources.</li> <li>• Expanding existing programs could have a large fiscal impact.</li> </ul>	
<p>DHCS Analysis: This recommendation could be accomplished through enhanced partnerships between the State and stakeholders. Many stakeholders are active in two existing projects – California Community Transitions and California Community Choices – both of which seek to build transitioning infrastructures at the local level. In order to accomplish this objective, both projects, which are limited in scope, depend on a high degree of coordination among nursing facilities, the Olmstead Advisory Committee, the California Health and Human Services Agency and various State departments. While the recommendation basically relies on entities and vehicles outside a skilled nursing facility for implementation, nursing facilities play a key role in the success of transition efforts. Without solid partnerships, expanding existing state programs and resources would likely only have an increased fiscal impact without success.</p>		

<p>Recommendation: A.7.i. Revise the Labor-Driven Operating Allocation (LDOA) currently used in Medi-Cal rate reimbursements. Divide LDOA into two parts: one part for meeting state staffing mandates and one part for staffing at levels above the minimum.</p>		
YEA: 0	NAY: 18	ABSTENTION: 0
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• This recommendation could provide an incentive for facilities to comply with or exceed the minimum staffing mandate.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• This recommendation is duplicative, in that the direct-labor cost component provides reimbursement for meeting the staffing mandate.</li> <li>• Revising the LDOA could redirect proceeds from the LDOA which are currently being used for facility quality-enhancement purposes outside direct-care staffing.</li> </ul>	
<p>DHCS Analysis: This recommendation provides performance incentives, for it would redirect existing LDOA payments to providers who meet or exceed minimum staffing mandates; however, the direct-labor cost component of the current rate-setting methodology already provides reimbursement for meeting the staffing mandate. Revising the LDOA as detailed in the recommendation could redirect proceeds currently being used for facility quality-enhancement purposes, to areas outside direct-care staffing. Revising the LDOA would require CMS approval of a SPA. Compliance with the minimum staffing mandate should continue to be addressed through CDPH oversight and monitoring, rather than through the LDOA.</p>		

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<p>Recommendation: A.7.ii. Repeal the labor-driven operating allocation established at Welfare &amp; Institutions Code §14126.023(c)(3). (This recommendation goes on further to state that the savings from the repeal of the LDOA should be used to pay for an increase in the minimum staffing requirements and/or to prevent cuts to community-based long-term care services.)</p>		
YEA: 6	NAY: 6	ABSTENTION: 6
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Community-based long-term care services could receive additional funding.</li> <li>• Additional funding would be available for increasing the minimum staffing requirements.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Funding for current facility spending would be redirected, and quality in certain facility spending areas could decline as a result of the redirection.</li> </ul>	
<p>DHCS Analysis: An increase in the minimum staffing requirements has the potential to improve the quality of care. However, increasing staffing requirements in the absence of quality measures would not allow for an assessment of the efficacy of the increased staffing requirements. Redirecting reimbursements from the facilities may lower current quality of care levels. CMS approval of a SPA would likely be necessary in order to implement this recommendation.</p>		

<p>Recommendation: 7.A.iii. The labor-driven operating allocation should be modified to increase incentives for better staffing; a part of the labor-driven operating allocation should be contingent on the facility meeting the state's minimum staffing requirements in the base year. Another part would rise in relation to the facility's staffing – the higher the average hppd level, the higher the labor-driven operating allocation.</p>		
YEA: 6	NAY: 11	ABSTENTION: 1
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Staffing levels could increase.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Current facility spending could be redirected from areas more critical to quality.</li> </ul>	
<p>DHCS Analysis: This recommendation is similar to Recommendation A.7.i. As touched upon in the analysis of A.7.i, the direct-labor cost component of the current rate-setting methodology already provides reimbursement for meeting the state's minimum staffing requirements. Also, revising the LDOA could redirect proceeds currently being used for facility quality-enhancement purposes, to areas outside direct-care staffing. DHCS maintains that compliance with the minimum staffing requirement should continue to be addressed through CDHP oversight and monitoring, rather than through the LDOA. Approval of a SPA from CMS would be necessary in order to implement the recommendation.</p>		

<p>Recommendation: A.8.i. Adjust the reimbursement methodology and reporting requirements for liability insurance. (This recommendation further states that each facility will be required to present proof annually of liability insurance and that costs of liability insurance policies from a carrier should continue to be reimbursed as a 100 percent. Self-insurance plans should be reimbursed by the state at 75 percent and be presented to the state and comply with certain standards of adequacy set by the state.)</p>		
YEA: 0	NAY: 18	ABSTENTION: 0
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Facility liability insurance costs would be more transparent.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• CMS approval of a SPA calling for dual cost caps may be difficult.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving quality.</p> <p>The recommendation that self-insurance plans be reimbursed at 75 percent would provide an incentive to the self-insured facilities to further control their costs in this area. Lowering the reimbursement rate for the self-insured facilities could also provide an incentive for the self-insured facilities to undertake efforts to increase facility safety and make improvements in other areas that would result in the filing of fewer claims. Facilities would still receive sufficient reimbursement for this legitimate business expense if PLI were capped at the 75<sup>th</sup> percentile. However, CMS approval of a SPA calling for dual costs caps (carrier costs versus self-insured costs) may be difficult.</p>		

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<p>Recommendation: A.8.ii. Repeal direct pass-through payment of liability insurance costs and impose reasonable cost controls on liability insurance. (This recommendation further states that insurance payments should be reimbursed as an administrative cost subject to the administrative cost cap and restricted to the median cost within the facility's peer group.)</p>		
YEA: 6	NAY: 6	ABSTENTION: 6
<p>PRO:</p> <ul style="list-style-type: none"> <li>• The imposition of cost controls could address high or outlier costs.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Subjecting the liability insurance costs to the 50th percentile cap of the administrative cost center may be excessive.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving quality.</p> <p>This recommendation would both lower reimbursements for liability insurance and also provide facilities with an incentive to undertake efforts to increase facility safety and make improvements in other areas that would result in the filing of fewer claims. The recommendation could also provide an incentive for self-insured facilities to further control the costs of their self-insurance programs. The savings that would result from implementing the recommendation could be used to provide quality improvement enhancements to the rate-setting methodology. CMS approval of a SPA would be necessary.</p>		

<p>Recommendation: A.8.iii. Reimburse liability insurance costs as an administrative cost in the administrative cost center, where it would be subject to the 50th percentile cap.</p>		
YEA: 11	NAY: 6	ABSTENTION: 1
<p>PRO:</p> <ul style="list-style-type: none"> <li>• The imposition of cost controls could address high or outlier costs.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Subjecting the liability insurance costs to the 50<sup>th</sup> percentile cap of the administrative cost center may be excessive.</li> </ul>	
<p>DHCS Analysis: This recommendation is largely duplicative of Recommendation A.8.ii., and does not appear to have a direct correlation with improving the quality of care.</p> <p>As stated in the analysis for A.8.ii, lowering reimbursements for liability insurance would provide facilities with an incentive to undertake efforts to increase facility safety and make improvements in other areas that would result in the filing of fewer claims. The recommendation could also provide an incentive for self-insured facilities to further control the costs of their self-insurance programs. The savings that would result from implementing the recommendation could be used to provide quality improvement enhancements to the rate-setting methodology. CMS approval of a SPA would be necessary in order to revise the reimbursement level for liability insurance.</p>		

<p>Recommendation: A.9.i. Provide a financial incentive in the rate system to reduce turnover and improve retention of nursing staff.</p>		
YEA: 6	NAY: 6	ABSTENTION: 6
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Implementation of this recommendation has the potential to improve staff retention levels and in turn improve the quality of care.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Depending on the amount of the incentive, the fiscal impact could be material.</li> <li>• If implementation of the recommendation were made budget-neutral, other facility spending areas could be adversely impacted.</li> <li>• Additional workload could be incurred relative to confirming turnover levels.</li> </ul>	
<p>DHCS Analysis: This recommendation calls for the incorporation of payment incentives into the rate-setting methodology for the purpose of reducing staff turnover. Any incentives built into the rate system should be concurrent with measures to confirm that the outcome results in quality of care improvements. Depending on the amount of the incentive, the fiscal impact could be material. CMS approval of a SPA would be necessary. DHCS' A&amp;I program or other departments may incur additional workload in confirming turnover levels.</p>		

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<p>Recommendation: A.9.ii. 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.</p>		
YEA: 12	NAY: 1	ABSTENTION: 5
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Implementation of this recommendation has the potential to improve staff retention levels and in turn improve the quality of care.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Depending on the amount of the incentive, the fiscal impact could be material.</li> <li>• If implementation of the recommendation were made budget-neutral, other facility spending areas could be adversely impacted.</li> <li>• Additional workload could be incurred relative to confirming turnover levels and performing the management audits.</li> </ul>	
<p>DHCS Analysis: Like Recommendation A.9.i., this recommendation calls for the incorporation of payment incentives into the rate-setting methodology for the purpose of reducing staff turnover. Any incentives built into the rate system should be concurrent with the development of measures to confirm that the outcome of any incentive program results in quality of care improvements, as stated in the analysis of A.9.i. Depending on the amount of the incentive, the fiscal impact could be material. DHCS' A&amp;I program or other departments may incur additional workload in confirming turnover levels and conducting the management audits, if data regarding turnover levels were not available elsewhere. CMS approval of a SPA would be required for changes to the rate-setting methodology.</p> <p>This recommendation would have been stronger if it specified how facilities that failed to comply with management audit recommendations would be penalized.</p>		

<p>Recommendation: A10.i. Require and fund home office audits to review corporate office expenses.</p>		
YEA: 12	NAY: 0	ABSTENTION: 6
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Auditing corporate office expenses would provide for more detail and transparency.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Additional staffing would be necessary.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>The recommendation is only feasible with increased audit staffing. However, obtaining the funding for the increased staffing is currently unlikely. Using other auditor's work (such as that of an independent Certified Public Accountant) is also not feasible. An independent auditor's opinion on the accuracy of an expense would not provide for an opinion from a reimbursement standpoint. The opinion of a Medicare or other State auditor would also not be relevant, due to the specifics of the AB 1629 rate-setting methodology.</p>		

<p>Recommendation: A.10.ii. Require nursing home chains to be audited as a group.</p>		
YEA: 17	NAY: 0	ABSTENTION: 1
<p>PRO:</p> <ul style="list-style-type: none"> <li>• This recommendation could result in auditors identifying and responding more effectively and efficiently to inappropriate or illegal corporate reporting practices.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Chain providers often request a staggering of audits to reduce staff time needed to work with DHCS auditors.</li> <li>• Space may not be available at the audit site for an audit team.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>The recommendation is feasible, but could create a burden on providers. Often, the providers request a staggering of audits to reduce staff time needed to work with DHCS auditors. Some providers may not be able to also accommodate an audit team in the space that they have available for auditors, if all of the facilities in the chain were audited at the same time. Currently, facilities comprising a chain are audited as a group, but not at the same time.</p>		

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Recommendation: A.10.iii. Require field audits once every two years and desk audits during intervening years.		
YEA: 12	NAY: 0	ABSTENTION: 6
PRO: • The audit process would be enhanced.	CON: • Additional A&I program staffing would be necessary. • The additional audits could be burdensome to providers.	
DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.		
The recommendation is only feasible with increased audit staffing. DHCS questions whether this recommendation is necessary, given the experience to date with the current practice of conducting a field audit once every three years.		

Recommendation: A.10.iv. Require DHCS to establish measures on audit system impact and report them on Medi-Cal's AB 1629 webpage.		
YEA: 12	NAY: 3	ABSTENTION: 3
PRO: • Implementation of this recommendation would make available meaningful information to stakeholders and the public on audit findings and impact. • Measures on the audit system impact could be used to identify and correct weaknesses in the design of the rate system.	CON: • Reporting audit findings may be of limited value to most stakeholders.	
DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.		
The recommendation is feasible, pending the implementation of the revisions to the OSHPD cost report format; however, the recommendation would have been stronger if it specified what is meant by measures on the audit system impact. Inclusion of audit findings and their impacts on the Medi-Cal's AB 1629 webpage would likely foster transparency.		

Recommendation: A.10.v. Establish clear definitions and provide clarification on problematic terminology. (Workgroup comments submitted in conjunction with this recommendation indicate that clarification is needed in the areas of audit disallowances and adjustments.)		
YEA: 17	NAY: 0	ABSTENTION: 1
PRO: • This recommendation would make the audit reports more user-friendly.	CON: • Audit staff would incur a minor one-time workload increase.	
DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.		
DHCS' A&I program will strive to clarify definitions and terminology.		

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Recommendation: A.10.vi. Require that rate adjustments based on audit appeals be paid within the overall cap.		
YEA: 6	NAY: 6	ABSTENTION: 6
<b>PRO:</b> <ul style="list-style-type: none"> <li>• This recommendation would assure that any rate change increase would not exceed the overall cap.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• The recommendation would require constant adjustment of rates for the entire population; thus, rates would never be "final".</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>Audit appeal recomputed rates are subject to ratcheting (lowering the rates based on the percent used to stay within the universal cap). However, the rates for the other facilities are not also ratcheted down, which thus allows for the original rate cap to be exceeded. In order for the original rate cap to not be exceeded each time a facility's rate is changed (such as the case when a rate is changed as the result of an appeal), the rate for each skilled nursing facility participating in Medi-Cal would have to be ratcheted down. This would result in rate changes for all facilities whenever a single facility's rate had to be changed.</p>		

Recommendation: A.10.vii. Consider establishing a combined rate review process and audit appeal process.		
YEA: 6	NAY: 0	ABSTENTION: 12
<b>PRO:</b> <ul style="list-style-type: none"> <li>• This recommendation would likely result in efficiencies for both DHCS' A&amp;I program and the providers.</li> <li>• The recommendation could result in some cost savings.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• DHCS' A&amp;I program would incur some minor one-time workload increase.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>DHCS acknowledges there may be opportunities for improving program efficiencies and will consider the potential of this recommendation.</p>		

Recommendation: A.11.i Cap management fees to parent corporations and salaries of owners and their families.		
YEA: 12	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• This recommendation would provide additional cost controls.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• Additional DHCS A&amp;I program staffing would be required.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>The associated savings resulting from the caps could be redirected for higher reimbursements in areas that would directly enhance facility quality of care. DHCS will examine the current salary levels for owners and their families as an initial step in consideration of implementing the recommendation. If the management fees were capped separately from other cost categories, additional audit staffing would be required, since the management fees would have to be separately identified. Currently, separately identifying the management fees is not an audit step. CMS approval of a SPA would be required in order to utilize a cap.</p>		

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<p>Recommendation: A.11.ii. 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.</p>		
YEA: 12	NAY: 6	ABSTENTION: 0
<p>PRO:</p> <ul style="list-style-type: none"> <li>• This recommendation would provide for additional cost controls and transparency.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Additional DHCS A&amp;I program staffing would be required.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>DHCS will examine the reasonableness of the current management fees before consideration of implementing the caps. The associated savings resulting from the caps could be redirected for higher reimbursements in areas that would directly enhance facility quality of care. The recommendation could only be implemented with increased audit staffing. CMS approval of a SPA would also be necessary, for utilizing caps. DHCS rate-setting staff will work with the audit staff to consider ways in which the rate system and cost audits could provide for a greater transparency of home office costs and management fees paid to parent corporations.</p>		

<p>Recommendation: A.12.i. AB 1629 Workgroup should be extended until 2012, operate as an advisory body to the Secretary of Health and Human Services, and generate annual reports addressing quality of care and quality of life issues.</p>		
YEA: 0	NAY: 16	ABSTENTION: 2
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Continuing the Workgroup could provide a mechanism for ongoing stakeholder input regarding the interface between the rate-setting methodology and quality.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• The costs of continuing the workgroup would fall on the state.</li> <li>• Continuing the workgroup would likely increase the workload for DHCS, CDPH, and the California Department of Aging (CDA) as these departments would likely continue to provide support to the Workgroup.</li> </ul>	
<p>DHCS Analysis: Continuing the Workgroup would result in additional costs to the state, both in terms of funding the Workgroup and in increased workload for the departments that would continue to provide support to the Workgroup, such as DHCS, CDPH, and CDA. The lack of consensus that existed among members of the original Workgroup would likely continue and thus hamper the ability of the workgroup to serve as an advisory body. This lack of consensus was largely responsible for the very limited outcomes of the original Workgroup.</p>		

<p>Recommendation: A.12.ii. 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.</p>		
YEA: 6	NAY: 7	ABSTENTION: 5
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Obtaining the measures called for under this recommendation would provide good indicators of quality.</li> <li>• Providers are currently not doing surveys in a uniform matter; implementation of this recommendation would foster consistency.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• Funding is currently not available for implementing this recommendation.</li> <li>• Regulations would be necessary for implementing the recommendation.</li> </ul>	
<p>DHCS Analysis: Measuring resident, family, and staff satisfaction is a worthwhile and a good indicator of quality (or a lack thereof). While funding is not currently available to pay for the State to develop a uniform data collection system, DHCS is actively evaluating the use of existing systems, such as the federal Minimum Data Set and 5-Star Facility Rating System for such purposes. DHCS is supportive of adding satisfaction levels and satisfaction improvement rates as publicly reported measures in California. DHCS is also interested in the possibility of incorporating into the rate-setting methodology reimbursement enhancements related to resident, family, and staff satisfaction levels.</p>		

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Recommendation: B.1.i. Require operators to increase caregiver wages and benefits annually by at least the percentage of rate increase.		
YEA: 6	NAY: 6	ABSTENTION: 6
<b>PRO:</b> <ul style="list-style-type: none"> <li>• Increases in caregiver wages have the potential for improving quality.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• Implementation of this recommendation would require a retroactive adjustment to the rates.</li> <li>• The costs associated with implementing this recommendation would be high, as caregiver wages represent a large component of facility spending.</li> <li>• Increases in caregiver wages would not be tied to quality measures.</li> </ul>	
<b>DHCS Analysis:</b> This recommendation is problematic for the following reasons: 1. Because rates are based on costs already incurred, a retroactive adjustment of the rates would have to be made to reimburse the providers who had provided a wage increase. 2. Confirmation of the rate increases would also be necessary, which would require additional audit staffing. 3. The recommendation as currently written does not provide for any quality measures to assess the efficacy of the wage increases. 4. CMS approval of a SPA would be necessary.		

Recommendation: B.1.ii. Increase the reimbursement rate to 100% of costs for RN direct care staffing and Gerontological Nurse Practitioner services in nursing homes.		
YEA: 6	NAY: 10	ABSTENTION: 2
<b>PRO:</b> <ul style="list-style-type: none"> <li>• This recommendation could encourage the hiring of additional RNs, which in turn could result in enhanced quality of care.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• The recommendation as currently written does not include any quality measures.</li> </ul>	
<b>DHCS Analysis:</b> The recommendation does not include any quality measures for assessing the efficacy of the increased reimbursement rate. Also, the currently rate-setting methodology is already providing complete reimbursement for RNs and Gerontological Nurse Practitioners if the facility's direct-care labor costs are not above the 90 <sup>th</sup> percentile. The increase of the reimbursement rate to 100 percent would require CMS approval of a SPA.		

Recommendation: B.1.iii. 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.		
YEA: 11	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• Quality might be enhanced to the extent that the prohibition on reimbursement for such legal fees would encourage changes in facility operating practices.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• Legal fees for defense of any cause of action are a legitimate cost for any business.</li> <li>• The Medi-Cal program only shares in these costs proportionate to the number of Medi-Cal residents cared for in the facility.</li> </ul>	
<b>DHCS Analysis:</b> This recommendation could provide an incentive for facilities to improve performance in the areas which are typically the subject of citations, deficiencies and investigation findings, as well as transfer and discharge appeals. However, providers might pass along such legal costs to their Non-Medi-Cal patients if the Medi-Cal rate methodology discontinued the reimbursement of legal fees for appeals. CMS approval of a SPA would be necessary.		

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Recommendation: B.1.iv. Increase the rate of nursing home administrator salary and benefit costs to the 90th percentile.		
YEA: 6	NAY: 11	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• Implementation of this recommendation could lower the current high turnover rate of facility administrators.</li> <li>• The increased reimbursements for administrators could attract more skilled and experienced candidates, which in turn could result in facility quality enhancements and higher staff retention levels.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• DHCS' A&amp;I program would incur an initial administrative burden.</li> <li>• No quality measures have been established to assess the effectiveness of the increased reimbursements under this recommendation.</li> </ul>	
<b>DHCS Analysis:</b> The increased reimbursement for administrator salaries and benefits could attract more skilled and experienced candidates. The presence of more competent administrators could result in facility quality of care improvements and increased staff retention. However, the absence of any associated quality measures is a shortcoming of the recommendation. The recommendation is feasible from a cost reporting standpoint, pending the implementation of the revised OSHPD cost report format. The DHCS' A&I program would incur a one-time administrative burden to establish the increase based on the State Administrator Compensation Guidelines, and CMS approval of a SPA would be required.		

Recommendation: B.1.v. Increase Quality Assurance Fee (QAF) revenues; the quality assurance fee should be extended to a facility's Medicare revenues.		
YEA: 11	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• Implementing this recommendation would result in annual increases in QAF revenues.</li> <li>• The increases in QAF revenues could go towards specific facility quality enhancement efforts.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• Implementation of this recommendation would increase the amount of the fee paid by all subject facilities, which in turn would likely increase the per-diem rates charged to private-pay patients.</li> </ul>	
<b>DHCS Analysis:</b> The additional QAF revenues generated could be earmarked for ongoing facility quality improvement efforts. However, in conjunction with any further consideration of the recommendation, DHCS suggests that the current facility-type QAF exemptions be revisited. The recommendation could be implemented without any additional resource or staffing need, but would require CMS approval of a waiver.		

Recommendation: B.1.vi. Recover Rate Overpayments to SNFs.		
YEA: 11	NAY: 6	ABSTENTION: 0
<b>PRO:</b> <ul style="list-style-type: none"> <li>• Reimbursements would be in alignment with costs.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• Retroactive adjustments or reconciliations could jeopardize the current prospective basis of the AB 1629 rate-setting methodology.</li> <li>• Staffing increases would be necessary in order to conduct a reconciliation of each facility.</li> <li>• Facilities might be inclined to lower existing spending, which could adversely impact quality.</li> </ul>	
<b>DHCS Analysis:</b> This recommendation does not appear to have a direct correlation with improving the quality of care. Implementation of the recommendation may not be feasible. In order to implement the recommendation, each facility would have to undergo an annual reconciliation, which would require the establishment of additional positions within DHCS. More importantly, the reconciliations and retroactive adjustments could jeopardize or void the current rate-setting methodology, being that it provides for prospective rates. This in turn could result in facilities with costs above their reimbursement rates receiving additional compensation. Finally, facilities might be inclined to spend less, given the possibility of payment recoveries, which could adversely impact quality. CMS approval of a SPA would likely be required.		

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Recommendation: B.1.vii. Ratesetting, following a Change of Ownership (CHOW), should be consistent when a facility has submitted six months of its own data.		
YEA: 16	NAY: 0	ABSTENTION: 1
<b>PRO:</b> <ul style="list-style-type: none"> <li>Rates for CHOW facilities would be more current relative to costs.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>This recommendation would require a retroactive change to rates, which could jeopardize the prospective basis of the AB 1629 methodology.</li> <li>Conducting timely audits of the six-month reports could be problematic, given current staffing levels and audit schedules.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>Implementing the recommendation could jeopardize the prospective basis of the AB 1629 methodology, in the absence of audits of the six-month reports. Specifically, DHCS' in-house legal counsel has stated that retroactive adjustments to rates set using the AB 1629 methodology could void the AB 1629 methodology, which sets rates on a prospective basis. Conducting audits of the six month cost reports on a timely basis could be problematic, given current staffing levels and audit schedules. Nonetheless, DHCS is committed to utilizing timely cost data reflective of new ownerships and will continue to explore options in this regard.</p>		

Recommendation: B.1.viii. Condition rate increases on compliance with minimum staffing requirements.		
YEA: 6	NAY: 6	ABSTENTION: 5
<b>PRO:</b> <ul style="list-style-type: none"> <li>This recommendation has the potential to increase the number of facilities in compliance with the minimum staffing requirements.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>The absence of rate increases could cause some facilities to close or lower spending, including spending in quality-sensitive areas.</li> <li>Additional staffing would likely be necessary to annually confirm that each facility is in compliance with the minimum staffing requirements.</li> <li>Implementing punishments, as well as financial incentives, in isolation, rather than as part of a comprehensive program, would not be as effective (as a program impacting all key elements of quality) and could actually have the unintended consequence of negatively impacting care in facilities that are penalized.</li> </ul>	
<p>DHCS Analysis: This recommendation calls for limiting rate increases to those facilities that are in compliance with the minimum staffing requirements. This recommendation could result in some facility closures and spending decreases among others. These spending decreases could in turn adversely impact quality. Additional staffing would likely be necessary in order to annually confirm that each facility is in compliance with the minimum staffing requirements. CMS approval of a SPA would be required. Compliance with the staffing requirements should continue to be addressed through the current CDPH monitoring.</p>		

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Recommendation: B.1.ix. 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.		
YEA: 6	NAY: 1	ABSTENTION: 10
PRO: <ul style="list-style-type: none"> <li>• This recommendation has the potential to improve resident care and safety, and employee safety.</li> <li>• Potential improvements in overall efficiency could lead to reductions in future operating costs.</li> <li>• Investment in health information technology is congruous with similar efforts at the state and national levels.</li> </ul>	CON: <ul style="list-style-type: none"> <li>• If this recommendation were to be implemented on a budget-neutral basis, as intended, a redistribution of spending would likely occur among facilities that increased spending for pass-through items covered under the recommendation.</li> </ul>	
DHCS Analysis: Incentivizing investment in medical information technology is directly supportive of overall federal and state-level goals to introduce more information technology into healthcare. If this recommendation were implemented, quality measures should be developed and implemented concurrently so that the impacts on quality could be gauged. Although a redistribution of spending might occur among facilities that increased spending for pass-through items that would be covered under the recommendation, the benefits of increased health information technology utilization could outweigh the costs of a spending redistribution. CMS approval of a SPA would be required.		

Recommendation: B.1.x. 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.		
YEA: 10	NAY: 6	ABSTENTION: 1
PRO: <ul style="list-style-type: none"> <li>• This recommendation has the potential for enhancing quality of care and increasing staff retention rates.</li> </ul>	CON: <ul style="list-style-type: none"> <li>• Additional staffing would likely be necessary for confirming the existence of active committees and monitoring the success of their efforts.</li> <li>• This recommendation may duplicate existing committees that facilities have organized for addressing quality and staffing issues. (Such types of committees are already required by state and federal regulations.)</li> </ul>	
DHCS Analysis: This recommendation may not be feasible from the standpoint of the oversight and monitoring that would be necessary to ensure that rate enhancements were only provided in those cases where the existence committees were resulting in tangible improvements in the quality of care and a proper vetting of staffing issues. Additional staffing would likely be necessary in order to provide sufficient oversight and monitoring. A more effective approach for enhancing facility quality and increasing staffing retention levels is to provide incentives on a system-wide basis using uniform quality measures. CMS approval of a SPA would be required.		

Recommendation: B.1.xi. Increase the percentile cap for direct patient care staff to create an incentive to increase wages and benefits for that staff. (This recommendation further states that the percentile cap should be increased to 95 percent of a facility's peer-group spending, with a mechanism to graduate this additional 5 percent to increases in wages and benefits for direct care staff over a set base year.)		
YEA: 1	NAY: 11	ABSTENTION: 5
PRO: <ul style="list-style-type: none"> <li>• This recommendation could increase spending on direct care labor with a resulting potential increase in quality of care and decrease in staff turnover.</li> </ul>	CON: <ul style="list-style-type: none"> <li>• This recommendation warrants further analysis, as 90 percent of facilities are currently receiving full reimbursement for their direct-care labor costs.</li> </ul>	
DHCS Analysis: This recommendation has the potential to improve the quality of care provided by facility staff. If this recommendation were to be implemented, quality measures should be developed and implemented concurrently in order to allow for an assessment of the efficacy of the higher cap in improving quality and staff retention levels. CMS approval of a SPA would be necessary in order to increase the percentile cap.		

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Recommendation: B.2.i. 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.		
YEA: 6	NAY: 10	ABSTENTION: 1
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• This recommendation would provide facilities with a higher degree of certainty regarding reimbursement levels.</li> <li>• The current tenuous status of the AB 1629 methodology could be precluding facilities from making capital improvements and engaging in higher spending levels in other areas; making the methodology permanent could incentivize facilities to do otherwise.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• Future revisions to the rate-setting methodology could be more difficult.</li> </ul>	
<p>DHCS Analysis: While DHCS is supportive of the basic underlying principles of the AB 1629 methodology, making the methodology permanent in its current form should not occur in the absence of additional analysis. The feedback that the legislature will be providing in response to the AB 1629 Workgroup's recommendations should also be considered. DHCS recognizes the need for a higher degree of certainty in the level of reimbursements, but at the same time acknowledges that the AB 1629 methodology would benefit from certain modifications, especially in terms of how the methodology could enhance facility quality of care.</p>		

Recommendation: B.2.ii. Have appeal information publicly available on the AB1629 website.		
YEA: 11	NAY: 6	ABSTENTION: 0
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• Greater transparency would be provided regarding the appeal process and specific appeals.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• Minor ongoing workload increases would be incurred.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>This recommendation is consistent with the Administration's commitment to transparency in Government.</p>		

Recommendation: B.2.iii. Clarify cost categorization and related definitions through adoption of regulations.		
YEA: 9	NAY: 0	ABSTENTION: 8
<p><b>PRO:</b></p> <ul style="list-style-type: none"> <li>• Such regulations could improve the accuracy in cost reporting and rate calculation.</li> <li>• Such regulations could reduce the number of audit and rate recalculation appeals.</li> </ul>	<p><b>CON:</b></p> <ul style="list-style-type: none"> <li>• The promulgation of regulations is a highly time-consuming process.</li> </ul>	
<p>DHCS Analysis: This recommendation does not appear to have a direct correlation with improving the quality of care.</p> <p>DHCS recognizes the importance and value of public input that is part of the regulatory process. However, the use of Provider Bulletins is critical to ensuring a rapid dissemination of important information. The time involved in promulgating regulations mandates that Provider Bulletins continue to be utilized for the rate-setting methodology updates and definitions. Nonetheless, DHCS is interested in working with stakeholders to provide additional clarity in the regulations as they are updated.</p>		

## AB 1629 Workgroup Recommendations Analyses

Recommendation: B.3.i. Review impact of current cost component caps in meeting AB 1629 goals in improving resident quality of care.		
YEA: 6	NAY: 2	ABSTENTION: 9
<b>PRO:</b> <ul style="list-style-type: none"> <li>• A review of the current cost component caps could be instrumental in assessing the efficacy of the AB 1629 methodology in fulfilling the intent of the methodology.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• A review of the current cost component caps would increase staff workload or require the services of an outside consultant.</li> </ul>	
<b>DHCS Analysis:</b> A review of the current cost component caps could be instrumental in assessing the impact of the AB 1629 methodology in a whole host of areas, particularly in the areas of facility quality of care and staff turnover levels. Such a review should ideally be conducted on a periodic basis. However, DHCS does not currently have the staffing resources for conducting the review, as well as outsourcing the review. Regardless of whether the review was conducted by DHCS staff or an outside consultant, the review would likely be a lengthy and costly process. Changes to the cost component caps could require CMS approval of a SPA.		

Recommendation: B.3.ii. Specifically review the Fair Rental Value System (FRVS) cost component to evaluate its impact in meeting AB 1629 goals of improving resident living and quality of life, and staff working environments.		
YEA: 6	NAY: 2	ABSTENTION: 9
<b>PRO:</b> <ul style="list-style-type: none"> <li>• A review would disclose why providers have thus far not made infrastructure improvements.</li> <li>• The AB 1629 methodology has been in place long enough to determine the impact of the FRVS.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• Such a review could be costly.</li> <li>• Such a review could require continuance of the workgroup.</li> </ul>	
<b>DHCS Analysis:</b> The results of such an analysis could be instrumental in improving facility quality of care, and possibly lowering staff turnover. However, DHCS' limited staffing resources might require that the review be outsourced to a consultant. This in turn would likely require that the competitive bid process be followed, which is typically a lengthy process. The review itself would also likely be lengthy, as well as costly. DHCS will also explore the possibility of utilizing an existing contract for conducting the analysis.		

Recommendation: B.3.iii. DHCS should revisit the peer grouping and analyze whether the current groupings are appropriately reimbursing facilities in different counties; additionally, a process should be established to review the composition of peer groups at least once every five years to assure that the goal of addressing geographic cost variations is being met.		
YEA: 13	NAY: 0	ABSTENTION: 4
<b>PRO:</b> <ul style="list-style-type: none"> <li>• A periodic review of the current peer groups utilized in setting the rates would disclose whether the peer groups are still reflective of the cost variances throughout the state.</li> </ul>	<b>CON:</b> <ul style="list-style-type: none"> <li>• A review of the peer groups would likely be a lengthy process involving material staffing resources and/or the use of an outside consultant.</li> </ul>	
<b>DHCS Analysis:</b> The peer groupings utilized in the rate-setting process should be revisited from time to time in order to determine whether they are still reflective of the cost variances throughout the state. Specifically, such a review could disclose whether facilities are being over or under compensated for certain cost categories. However, DHCS' limited staffing resources would likely require that the review be outsourced to a consultant. DHCS will explore the possibility of using an existing contract to review the peer groups. CMS approval of a SPA would be necessary if the peer groups were changed.		

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Recommendation: B.3.iv. Measure and report the impact of the universal cap on Medi-Cal rates. (This recommendation further states that DHCS will report annually, beginning in February 2010, to the Legislature the impact of the universal cap.)		
YEA: 7	NAY: 4	ABSTENTION: 6
PRO: • An ongoing periodic review of the universal cap would disclose the appropriateness of the level of the cap.	CON: • DHCS' limited staffing levels would likely preclude the implementation of this recommendation.	
DHCS Analysis: DHCS is interested in an ongoing periodic review of the impact of the universal cap on Medi-Cal rates. However, the length of time that would be necessary to develop the measurement tool, conduct the analysis, write the report and submit it for review would not allow DHCS to meet the February 2010 deadline. Also, DHCS would need additional staff to conduct the review on an ongoing basis. CMS approval of a SPA would be necessary for a change in the universal cap.		

Recommendation: B.4.i. Clarify cost categorization and related definitions through adoption of regulations.		
YEA: 8	NAY: 0	ABSTENTION: 9
PRO: • Please see Recommendation B.2.iii.	CON: • Please see Recommendation B.2.iii.	
DHCS Analysis: This is a duplicate of Recommendation B.2.iii. Please see B.2.iii for the DHCS analysis.		

Recommendation: B.4.ii. 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.		
YEA: 11	NAY: 6	ABSTENTION: 0
PRO: • This recommendation could result in increased compliance with the staffing standards.	CON: • This recommendation would require a change in statute. • The reporting requirement would likely be considered a mandate, which would require an enhancement to the Medi-Cal rates. • The submission of self-reported data would be unaudited and thus subject to possible inaccuracies. • Regulatory citations and penalties are outside the purview of the Workgroup.	
DHCS Analysis: The recommendation that staffing standards should be an automatic B penalty and the amount of the B penalty increased is outside the purview of the Workgroup.		
Increasing the penalty to the B level could increase number of facilities that meet the staffing standards. Nonetheless, compliance with the staffing standards should continue to be addressed through the current CDPH monitoring. The recommendation requiring reporting of non-compliance incidents would be considered a mandate, and the associated costs would require an enhancement to the Medi-Cal rates. Also, the submission of self-reported data would be unaudited and thus subject to possible inaccuracies. The recommendation would require a change in statute.		

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<p>Recommendation: B.4.iii. 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.</p>		
YEA: 11	NAY: 6	ABSTENTION: 0
<p>PRO:</p> <ul style="list-style-type: none"> <li>• Providing additional information on the CDPH website would likely be of value to consumers and other stakeholders.</li> <li>• Increases in the penalty amounts could result in higher levels of compliance.</li> </ul>	<p>CON:</p> <ul style="list-style-type: none"> <li>• The penalty increases may not be sufficient for encouraging higher levels of compliance.</li> <li>• Regulatory citations and penalties are outside the purview of the Workgroup.</li> </ul>	
<p>DHCS Analysis: The recommendation that the penalty for "AA," "A" and "B" citations be increased is outside the purview of the Workgroup.</p>		
<p>The CDPH website can be modified to include additional information about facility citations issued starting July 1, 2009, beginning with the posting of AA citations. The posting of this additional information could provide for increased consumer awareness and empower consumers and their families to make more informed decisions about selecting long-term care facilities. Regarding the recommendation to increase penalty amounts, pending legislation, AB 773 (Lieu) includes such a provision.</p>		