Inside California's Nursing Homes

A Primer for Evaluating the Quality of Care in Today's Nursing Homes

California Senate Office of Research

Inside California's Nursing Homes

A Primer for Evaluating the Quality of Care in Today's Nursing Homes

by Michelle Baass
February 2009

California Senate Office of Research

Contents

Executive Summary

Nursing homes play an important role in California's health care system, providing care to about 100,000 people—primarily the elderly and people with disabilities—who are temporarily or permanently unable to care for themselves but who do not require acute care. In 2004 the California Legislature passed the Medi-Cal Long Term Care Reimbursement Act of 2004 (Assembly Bill 1629, Frommer, Chapter 875, Statutes of 2004) with the intent of improving the quality of care provided in the state's nursing homes. This law, which sunsets on July 31, 2011, imposes a quality assurance fee on skilled nursing facilities and requires using these funds to leverage a federal match in the Medi-Cal program to provide additional reimbursements to nursing facilities that support improvement efforts. This report provides background information on nursing homes and California Assembly Bill 1629, including stakeholder perspectives and recommendations.

Nursing Home Background

What Is a Nursing Home?

California state law defines a skilled nursing facility as a place that provides continuous skilled and supportive care on an extended basis.[1] Such care comprises 24-hour inpatient treatment, including physician, skilled nursing, dietary, pharmaceutical, and activity services. Most facilities serve the elderly, however some provide services to younger individuals with special needs, such as those with developmental or mental disabilities and those requiring drug and alcohol rehabilitation. Generally, nursing homes are stand-alone facilities, though some are operated within a hospital or residential care community.

Nursing Home Statistics

Tables 1, 2, and 3 on pages 6, 7, and 8 show California and national nursing home data acquired from the federal Online Survey, Certification, and Reporting (OSCAR) database, which records state survey information.

The number of nursing homes and beds has remained relatively constant since 2001 and is anticipated to remain stable in the future, even though the population of California residents age 65 and older is projected to nearly double by 2025.[2] This lack of nursing home growth reflects the increasing preference for alternatives to facility-based care and the growth in the number of assisted living facilities[3] (assisted living facilities offer help with daily living activities, such as eating, bathing, and dressing, but generally do not provide intensive medical care).

Table 1

Certified Nursing Homes in California and the United States

	2001	2002	2003	2004	2005	2006	2007
No. of Nursing Homes							
California	1,147	1,190	1,291	1,278	1,228	1,189	1,197
U.S.	14,997	15,162	15,209	15,138	14,942	15,294	15,281
No. of Beds							
California	105,504	110,170	121,261	120,460	116,339	113,527	115,158
U.S.	1,526,066	1,573,990	1,579,862	1,573,425	1,567,024	1,614,771	1,613,942
Occupancy Rate							
California	84.9%	84.9%	85.5%	84.3%	85.2%	85.6%	84.7%
U.S.	85.9%	85.6%	85.5%	85.5%	85.4%	85.2%	84.8%
Medicare Payer							
California	8.9%	10.0%	10.6%	11.2%	11.8%	12.7%	12.9%
U.S.	9.8%	10.7%	11.7%	12.2%	13.1%	13.4%	13.7%
Medicaid Payer							
California	65.8%	66.2%	66.4%	66.2%	66.4%	65.6%	65.4%
U.S.	66.9%	66.7%	66.2%	65.7%	65.4%	64.8%	64.1%
Other Payer							
California	25.3%	23.8%	23.0%	22.5%	21.9%	21.7%	21.6%
U.S.	23.3%	22.6%	22.0%	22.0%	21.6%	21.8%	22.2%
For Profit							
California	76.8%	77.4%	77.5%	79.2%	78.7%	79.7%	78.8%
U.S.	65.0%	65.5%	65.5%	65.9%	66.0%	66.4%	66.8%
Nonprofit							
California	19.3%	18.5%	18.4%	17.4%	17.3%	16.5%	16.7%
U.S.	28.6%	28.3%	28.2%	28.0%	28.1%	27.5%	27.0%
Government Owned							
California	3.9%	4.1%	4.0%	3.4%	3.9%	3.8%	3.8%
U.S.	6.4%	6.2%	6.3%	6.1%	6.0%	6.1%	5.9%

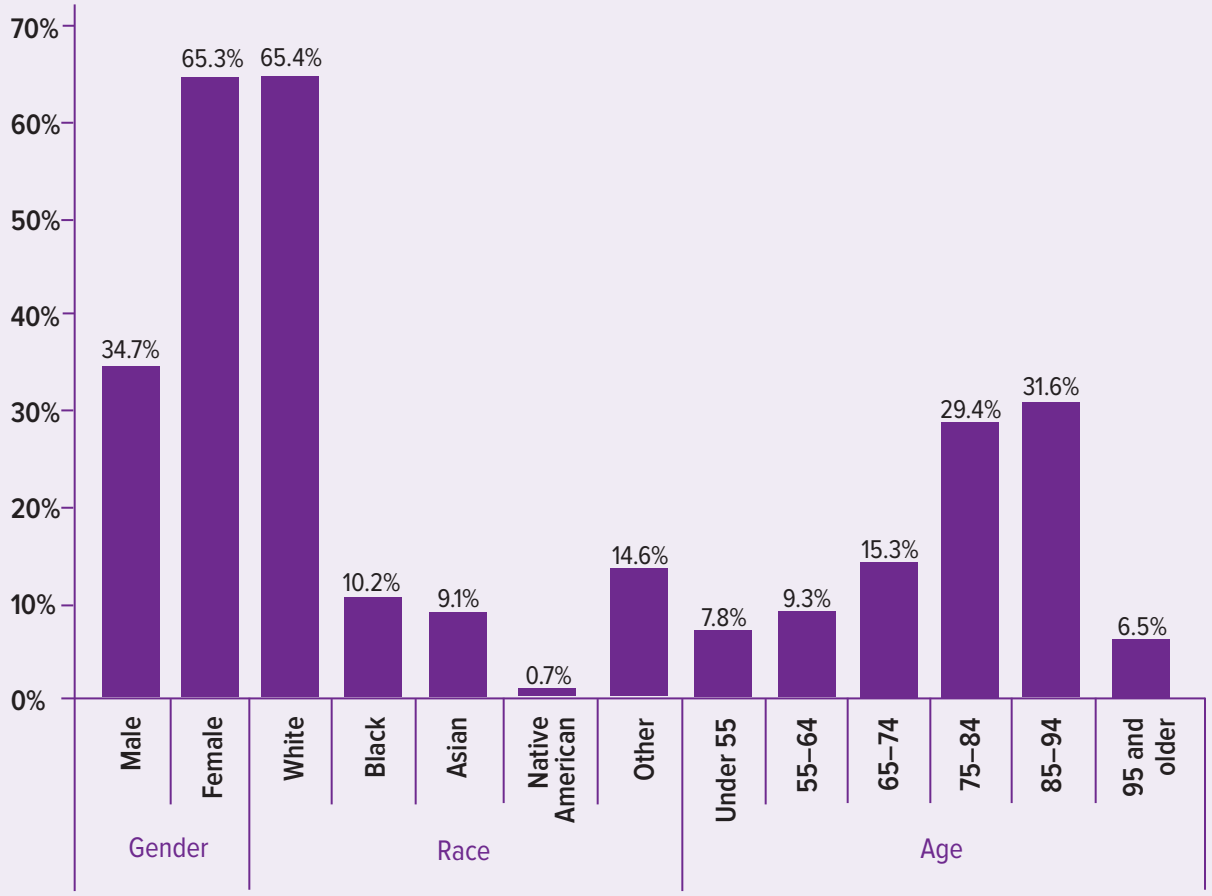
Table 2

Average Length of Stay in a California Nursing Home

Length of Stay	2001	2002	2003	2004	2005	2006	2007
Less than 3 months	74.3%	73.5%	74.5%	76.3%	76.9%	78.4%	76.2%
3 months to less than 7 months	9.4%	9.7%	9.5%	9.1%	8.8%	8.5%	8.6%
7 months to less than 1 year	5.6%	5.6%	5.4%	5.1%	4.8%	4.8%	4.6%
1 year to less than 2 years	4.7%	5.0%	4.7%	4.2%	4.2%	3.7%	4.0%
2 years to less than 3 years	2.4%	2.6%	2.6%	2.2%	2.2%	2.0%	2.1%
Greater than 3 years	3.6%	3.6%	3.4%	3.2%	3.2%	2.7%	4.5%

Table 3

California Nursing-Home-Resident Demographics (2007)



Note: Approximately 15 percent of nursing home residents are of Latino ethnicity and may be included in any of the above race categories.

How Are Nursing Homes Evaluated and What Is Evaluated?

The Licensing and Certification (L&C) Division of the California Department of Public Health is responsible for ensuring and promoting a high standard of care in nursing homes throughout the state. To accomplish this, L&C (1) conducts certification surveys for participation in the federal Medicare and Medicaid (Medi-Cal in California) programs, (2) conducts state licensing reviews and ensures compliance with state law, (3) issues federal deficiencies and state citations, imposes sanctions, and assesses monetary penalties on those facilities that fail to meet certain requirements, and (4) investigates consumer complaints about health care facilities and incidents reported by the facilities (these complaints may be received via telephone, mail, personal contact, or during a facility inspection).

Surveys are performed by experienced nursing-home-care teams (generally health-facility evaluator nurses) who have backgrounds in nursing, social work, dietetics, sanitation, health care administration, and counseling. Nursing home surveyors must pass a qualifying test administered by the federal government.

Survey Focus Areas. Surveyors focus on (1) the quality of care and quality of life in the facility, (2) whether residents' rights are observed, and (3) whether the facility is safe and meets environmental standards for cleanliness. Facilities that do not meet these standards must correct the deficiencies or face a variety of penalties and sanctions.

Frequency. Under state law, L&C must survey a skilled nursing facility (SNF, pronounced *sniff*) at least once every two years; under federal law, L&C must survey a SNF at least once every 15 months, with the statewide average not to exceed 12 months. In addition to these routine surveys, the Department of Public Health may also conduct a survey in response to complaints filed against a nursing home.

A nursing home is not notified in advance of a survey unless it is an initial survey; unannounced surveys allow a team to see candidly how a facility operates on a daily

basis. When a survey team arrives at a nursing home, team members place a sign in the lobby informing everyone that a survey is in progress.

Survey Activities. Prior to beginning a survey, team members review the nursing home's background, including previous survey results, complaint investigations, and incident reports. They also consult with the long-term-care ombudsperson assigned to the facility, who will alert them to any special concerns or problems they should be aware of during the survey.

Surveyors observe what is happening in the nursing home and they interview residents, family members, and nursing home employees, and read medical records and other documents. They also meet with nursing home staff. The surveyors verbally summarize their observations to the facility staff at the conclusion of their visit.

Inspecting for Federal and State Requirements. In 2005 the California Legislature held oversight hearings regarding L&C. During these hearings it was highlighted that L&C did not routinely conduct evaluations of nursing homes specifically for their compliance with state laws and regulations. At the time, state law violations were noted only if they happened to be found during an inspection for compliance with federal rules, and only in those instances did L&C follow up on a state action.

This was an important policy matter because state and federal legal requirements for nursing homes vary significantly. For example, California's laws and regulations regarding abuse-reporting requirements are stronger than federal nursing home standards. Consequently, Senate Bill 1312 (Alquist, Chapter 895, Statutes of 2006) was passed and requires L&C to inspect all licensed long term care health facilities to ensure compliance with state laws and regulations when those standards provide greater protection to residents or are more precise than federal standards.

Licensing and Certification Divison

Staff. The Licensing and Certification (L&C) Division of the California Department of Public Health has about 1,000 employees—more than 500 are nurse surveyors—in 19 district offices throughout the state. This staff conducts approximately 1,350 on-site inspections of nursing homes annually and responds to about 5,000 complaints and 5,300 events reported by facilities in the same time frame. (The California Department of Public Health contracts with Los Angeles County to perform the county's inspections in lieu of providing L&C staff for that job.)

From 2000 to 2004 L&C deleted more than 160 positions due to unfilled vacancy reductions and unallocated budget reductions. And in 2005 when the Senate conducted oversight hearings regarding L&C's operations, advocacy and consumer protection organizations voiced several concerns, such as L&C's delayed responses to, and investigations of, complaints. Additionally, an investigation conducted by the U.S. Government Accountability Office found that from July 2003 through January 2005, L&C failed to identify serious deficiencies in 17 percent of its surveys.

To address these issues and as a part of a larger reform of the L&C program, the 2006 and 2007 budget acts added 127 health-facility evaluator nurses to the L&C staff to address their workload issues and help implement newly enacted legislation, including Senate Bill 1312 (outlined on page 10) and Senate Bill 1301 (Alquist, Chapter 647, Statutes of 2006), which establish time frames for follow-up investigations and require reporting serious medical errors to the Department of Public Health within set periods of time.

Given past difficulties in recruiting and retaining health-facility evaluator nurses (there is competition for nurses from the private sector and other state departments, which can offer higher salaries), L&C took several steps to aid in nurse recruitment. For example, L&C shortened the length of time it takes to get a newly hired nurse trained and tested from 18 to 24 months

to 12 to 18 months, and a postcard was mailed to every registered nurse in the state to solicit recruits for L&C positions. Consequently, according to L&C, the vacancy rate for health-facility evaluator nurses is currently 7.5 percent (compared to 10 percent in 2003), and at the end of May 2008 all 127 evaluator nurse positions added by the 2006 and 2007 budget acts had been filled. In the 2008 budget, 32 more health-facility evaluator nurse positions were added to help satisfy requirements established by Senate Bill 1312.

Funding. The L&C program is supported by federal funds (to support the work L&C performs on behalf of the federal government), the General Fund (to support licensing activities associated with state-operated facilities such as state hospitals), and licensing fees. The 2006 budget increased licensing fees to support a greater portion of L&C program costs, thereby reducing the need for General Fund support for these activities. A new special fund was created to track the license fees collected and spent by L&C.

How Is the Quality of Care in Nursing Homes Measured and Reported?

Various indicators can be used to evaluate the quality of nursing home care and they should be considered in the context of the case mix, or acuity level, of a facility's residents. For example, facilities with residents who have high-care needs require more nursing staff time than facilities with residents who have low-care needs.

Data regarding these indicators are reported to the federal and state governments in many ways. The federal government has two national reporting systems: the Online Survey, Certification, and Reporting (OSCAR) database and the national Minimum Data Set (MDS). In addition to these systems, nursing homes are required to submit data annually to the Office of Statewide Health Planning and Development.

What follows is a description of how the quality of care in nursing homes may be measured and where this information is reported and available to the public.

Adequate Nursing Staff. Numerous studies have shown a positive association between nurse staffing levels and the quality of care provided in nursing homes.[4] Additionally, research suggests that the ratio of professional nurses—registered nurses (RNs) and licensed vocational nurses (LVNs)—to other nursing personnel—such as certified nurse assistants (CNAs)—is an important predictor of the quality of care received. Having a greater number of professional nurses appears to have a positive effect on the lives of residents.[5]

In general, methods that address problem areas and improve residence independence (such as adult toilet training, walking-improvement programs, and the "turning" schedule for reducing pressure ulcers of bedridden patients) require more staff time.[6] Consequently, in nursing homes with inadequate nursing help, staff may resort to care practices that reinforce dependence and functional decline; for example, staff may assist residents who have urinated on themselves by changing their clothing for them because this takes significantly less time than training them how to properly use

the toilet, even though adult toilet training can promote continence. See “Standards for Nurse Staffing Levels” on the opposite page for more details on California’s staffing requirements.

As a part of the survey process, each nursing home must report on its staffing levels for the two-week period preceding the survey. State staff enters this information into the OSCAR database (OSCAR staffing data do not undergo formal audits, and the data for the two-week period preceding the survey may or may not be an accurate reflection of facility staffing throughout the year). A facility’s staffing information—and how it compares to state and national averages—can be viewed by the public on the Nursing Home Compare Web site,[7] which is maintained by the federal government; this Web site contains performance information on all nursing homes that participate in Medicare and Medi-Cal.

Nursing homes also report staffing level information to the Office of Statewide Health Planning and Development (OSHPD) in their annual financial data report. Most data reported to OSHPD are available on OSHPD’s Web site, however, it is not presented in a manner that can be easily understood by most consumers.

Standards for Nurse Staffing Levels

Registered nurses, licensed vocational nurses, and certified nurse assistants represent the largest component of nursing home personnel.

Federal Requirements. Federal law requires "sufficient staff" to provide nursing and related services to attain or maintain the "highest practicable level" of physical, mental, and "psychosocial" well-being of each resident, although the federal law and implementing regulations do not provide specific standards or guidance about what constitutes sufficient staffing. A report commissioned by the Centers for Medicare and Medicaid Services indicates that a minimum of 4.1 nursing hours per resident day (NHPRD) is needed to prevent harm to nursing home residents.

State Standards. California established a minimum nurse staffing level of 3.2 NHPRD in 2000. While such hour ratios permit facilities to more readily schedule staff for the easier-to-fill shifts, other shifts, like the night shift, can be understaffed. Given such concerns, Assembly Bill 1075 (Shelley, Chapter 684, Statutes of 2001) required the Department of Health Services (now the Department of Public Health) to develop regulations by August 1, 2003, that would establish a staff-to-resident ratio for direct caregivers working in a SNF. The bill also includes a provision specifying that these regulations are contingent upon an appropriation.

Since the Department of Public Health (DPH) did not meet the deadline to promulgate regulations per the requirements of Assembly Bill 1075, a consumer advocate organization entered into litigation against DPH. Consequently, a court ordered the department to complete the regulations and mandated that the regulations would become effective on or before October 12, 2007; these regulations became effective on January 22, 2009, but are not yet operational because there has been no appropriation of funds.

As a part of the emergency regulations, DPH stipulated that $208 million in funds (which would include $104 million from the General Fund) would be necessary annually to implement the regulations. The Governor Arnold Schwarzenegger Administration has not requested, nor has the Legislature included, an appropriation for this regulation.

.

Nurse Retention and Staff Satisfaction. Another quality indicator related to nursing is staff retention and satisfaction. High turnover rates may affect the continuity and stability of resident care.[8] Research indicates that high turnover rates have been associated with worse outcomes for patients and a lower quality of care, such as increased rates of residents with pressure sores.[9]

Nursing homes are required to report labor turnover information annually to OSHPD and this information is available on OSHPD's Web site. Yet information regarding staff satisfaction is not systematically collected or reported by the state.

Deficiencies, Citations, and Complaints. Another method of evaluating the quality of care is how well a nursing home complies with federal and state requirements.[10] As described earlier, L&C conducts periodic surveys to determine whether nursing homes are compliant with federal and state regulations. A high number of deficiencies can be associated with a lower quality of care.[11] Moreover, research indicates that consumer complaints are valuable indicators of nursing home quality because they provide perspective on what occurs at a nursing home between L&C surveys.

Information about federal violations that were identified during state surveys of nursing homes are entered into the OSCAR database by state staff and may be viewed on the Nursing Home Compare Web site. As required by Assembly Bill 893 (Alquist, Chapter 430, Statutes of 1999), state citation and complaint information also is available on a consumer Web site[12] maintained by the Department of Public Health.

Clinical Indicators. The quality of nursing home care also may be evaluated by analyzing clinical indicators. According to the Institute of Medicine, a nonprofit organization that provides health and science policy information to policy makers, professionals, and the public at large, pressure sores, malnutrition and dehydration, continence care, pain management, hospitalization, the use of physical and chemical restraints, and the overall quality of life are some of the quality indicators used to evaluate nursing homes.[13]

Caretaking results generally are assessed by evaluating changes in a patient's health status and other conditions attributable to the care provided—or not provided—to the patient. The occurrence of specific problems, such as pressure sores or inappropriate weight loss, is generally viewed as evidence of poor quality care.

Research suggests that clinical indicators may not be as reliable as the quality-of-care indicators previously outlined because clinical information is inconsistently reported by nursing homes and generally not audited.[14]

Information from the national Minimum Data Set (MDS) provides methods to measure clinical quality at nursing facilities. Every nursing facility must do a periodic comprehensive assessment of each resident's functional capabilities and medical needs and submit that information to the Centers for Medicare and Medicaid Services. The federal government has collected these data at the national level and constructed various quality indicators and measures for each nursing facility; this information is available at the Nursing Home Compare Web site. However, several issues have been raised concerning the MDS data, including: (1) accuracy of the data, (2) validity of the quality indicators and measures used to provide risk-adjusted measures of nursing home quality, and (3) consistency of reporting among facilities and from state to state—as well as over time.

Assembly Bill 1629: The Medi-Cal Long Term Care Reimbursement Act of 2004

New Reimbursement System. Assembly Bill 1629 (Frommer, Chapter 875, Statutes of 2004) enacted the Medi-Cal Long Term Care Reimbursement Act of 2004, which establishes a reimbursement system that bases Medi-Cal reimbursements to skilled nursing facilities (SNFs) on the actual cost of care. (SNFs that are part of a continuing care retirement community, operated by the state or another public entity, or that are part of a general acute-care hospital, are exempt.) Prior to Assembly Bill 1629 (which now sunsets on July 31, 2011), SNFs were paid a flat rate per Medi-Cal resident. This flat rate system provided no incentive for quality care and reimbursed SNFs for less than it cost to care for their residents. According to a report published in 2001 by the California Department of Health Services, approximately 11 percent of nursing homes had filed for bankruptcy as of August 2000.[15]

Assembly Bill 1629 Reimbursement Formula. The reimbursement system established by Assembly Bill 1629 focuses on specific cost categories: direct resident care (limited to the 90th percentile, that is, the costs are limited to what the lower 90 percent of the state's facilities spend on direct resident care); indirect care (limited to the 90th percentile); indirect care, nonlabor costs (limited to the 75th percentile); administrative costs (limited to the 50th percentile); capital costs (based on the fair rental value system); direct reimbursement of certain expenses (property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance); and labor-driven operating allocation. In addition, the statute specifies a cap on the maximum annual increase of the reimbursement rate compared to the prior fiscal year. (This cap was included to protect the General Fund from exposure to dramatic increases in reimbursement rates.)

Assembly Bill 1629 does not require skilled nursing facilities to meet quality standards or make improvements in the quality

of care in exchange for reimbursement eligibility.

Labor-Driven Operating Allocation. The Assembly Bill 1629 reimbursement system established the labor-driven operating allocation (LDOA) as an additional payment (above actual expenditures) that can be used for any allowable Medi-Cal expense. It is equal to 8 percent of labor costs, minus expenditures for temporary staffing. According to the California Department of Health Care Services, the LDOA is essentially a profit margin that links annual return to labor costs, thereby encouraging facilities to hire, train, and retain permanent staff and fund competitive wages. In 2006–07 LDOA expenditures from the state to SNFs were $155.6 million; in 2007–08 they were $165.4 million. Nursing facilities receive this additional payment irrespective of their compliance with state and federal requirements.

Quality Assurance Fee. Assembly Bill 1629 also allows the state to leverage new federal Medicaid dollars by imposing a quality assurance fee on SNFs. This new federal funding is used to increase nursing-home reimbursement rates. (Federal Medicaid law allows states to impose such fees on certain health-care service providers and in turn repay the providers through increased reimbursements.) Because the costs of Medicaid reimbursements to health care providers are split between states and the federal government (in California the split is 50:50 with the federal government), this arrangement provides a method by which states can leverage additional federal funds for the support of their Medicaid programs and offset state costs. (See the appendix on page 43 for the Department of Health Care Services' projections on General Fund savings resulting from Assembly Bill 1629.)

Intent of Assembly Bill 1629. As stated in this bill, it is the California Legislature's intent that implementation of Assembly Bill 1629 and the new reimbursement system would result in increased individual access to appropriate long term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, provider compliance with all applicable state and federal requirements,

and administrative efficiency. Prior to the bill's adoption, numerous reports by the U.S. Government Accountability Office (GAO) found persistent quality problems in nursing homes in California. Specifically, in a 1998 study, the GAO found that serious and potentially life-threatening quality of care problems in the categories of neglect, abuse, malnutrition, and pressure sores occurred in approximately 30 percent of California nursing homes over a two-year period.[16] Moreover, only 2 percent of California SNFs had minimal or no deficiencies.

The GAO also found that nearly 10 percent of California nursing homes serving thousands of residents were cited twice for "actual harm" violations, strongly suggesting that these homes were not correcting problems. Between 1995 and 1998 nearly three-quarters of the 122 facilities in California cited for serious deficiencies in at least the last two consecutive years had never faced federal intermediate sanctions.[17] See "The Quality of Nursing Home Care Before and After Assembly Bill 1629" on page 26 for specific measurements of care quality provided in California's nursing homes prior to this bill.

What Has Been Accomplished Since Assembly Bill 1629 Went Into Effect?

Assembly Bill 1629 Evaluations. Two reports released in spring 2008 evaluated the effects of Assembly Bill 1629;[18] the first study was completed by a team of researchers at the University of California, San Francisco, and led by Professor Charlene Harrington, and the second was led by Professor John Schnelle from Vanderbilt University. These reports found the following:

- Nursing facility revenues and expenditures per resident day generally increased.
- Nursing staff turnover rates slightly increased.
- Wages for certified nurse assistants decreased (after inflationary adjustments).
- Deficiency citations increased in 2006. (Schnelle points out that this increase in deficiencies may be the result of an increase in L&C staff; however, L&C surveyor staff was not increased until the 2006–07 budget act, and since new surveyor training typically takes from 12 to 18 months, these new staff positions would not have been filled and trained until 2007.)
- Nurse staffing levels slightly increased.

Harrington found that (1) the new reimbursement methodology did not improve quality as measured by complaints (the number of complaints increased by 38 percent between 2004 and 2006), (2) 16 percent of SNFs in 2006 did not meet the state's minimum staffing standard of 3.2 nursing hours per resident day, (3) administrative expenditures (such as liability insurance) increased by 15.4 percent between 2004 and 2006, (4) expenditures for direct care declined by 3.7 percent between 2004 and 2006, and (5) wages for nursing facility administrators and licensed nurses increased by 12.3 percent and 2 percent (when adjusted for inflation), respectively. Although Harrington indicates that these findings are from the initial period after implementation of Assembly Bill 1629, she argues there is no evidence to indicate that the new reimbursement incentives are sufficient to improve the quality of nursing home care.

In contrast, Schnelle concludes that his evaluation of the effects of Assembly Bill 1629 is limited and preliminary because 2006 (the last year in which data were used in both evaluations) was the first full year of the new rate reimbursement system. Furthermore, he notes that long delays—from 31 to 39 months—between facility spending and the state's recognition of this spending through an adjusted rate may be a reason why nursing homes are reluctant to increase staffing levels, wages, and benefits. Consequently, Schnelle believes that future evaluations should be conducted to understand the full effects of the bill.

Schnelle also conducted a survey of California nursing homes and received a response rate of 24 percent (249 nursing homes): 95 percent of the respondents said they made staffing investments as a result of Assembly Bill 1629, 83 percent reported they will make future investments because of the bill, and 35 percent thought the bill could be improved by expediting the reimbursement process.

The California Department of Public Health Report. The Department of Public Health submitted a report to the California Legislature on January 1, 2009, providing information about various indicators of the quality of care provided in freestanding SNFs two years after implementation of Assembly Bill 1629. The department compared this information to quality indicators from three years *prior* to the bill's implementation. This comparison is intended to show how the bill impacted quality of care; see "The Quality of Nursing Home Care Before and After Assembly Bill 1629" on page 26.

Increase in CNA Wages. The Service Employees International Union (SEIU) represents workers in approximately 17 percent of the state's SNFs. (SEIU typically represents certified nurse assistants, dietary aids, cooks, housekeeping and laundry workers, and other nonmanagement-level employees.) According to SEIU, because of the new funding provided by Assembly Bill 1629, their workers received wage increases

ranging from $2.25 to $3 per hour (a 19 to 28 percent increase) over approximately 30 months (most wage increases were provided on January 1st of 2006, 2007, and 2008) and improvements in employer contributions toward health insurance premiums. For the three-year contract period prior to Assembly Bill 1629, the average wage increase was approximately 10 percent over the three-year period.

Clinical Indicators. Although research suggests that clinical indicators as measured by the national Minimum Data Set are unreliable and potentially inconsistent, this information is often used by consumers via federal and consumer-oriented Web sites to evaluate nursing home quality. Table 4 on the opposite page describes certain clinical indicators identified by the Institute of Medicine as measures of the quality of nursing home care for California and the nation from 2000 to 2007; the only significant improvements in care quality for the period measured were the reduction of incontinence for all patients in California without a toileting plan and the reduced use of physical restraints. Otherwise, these clinical indicators have not significantly improved since implementation of Assembly Bill 1629.

Table 4

Centers for Medicare and Medicaid Services' Minimum Data Set Quality Indicators

	2000	2001	2002	2003	2004	2005	2006	2007
Prevalence of Incontinence Without a Toileting Plan								
California	46.0%	40.8%	43.1%	39.6%	39.9%	38.8%	38.0%	37.8%
U.S.	42.0%	43.5%	42.5%	42.5%	44.1%	44.7%	45.3%	45.7%
Prevalence of Indwelling Catheters								
California	8.5%	8.7%	8.9%	8.9%	8.5%	8.3%	8.2%	8.0%
U.S.	9.2%	8.1%	8.1%	8.0%	8.0%	7.9%	7.7%	7.5%
Prevalence of Fecal Impaction								
California	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
U.S.	0.4%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
Prevalence of Weight Loss								
California	10.4%	10.4%	9.8%	10.4%	9.3%	8.9%	8.6%	8.5%
U.S.	10.9%	11.4%	11.1%	11.0%	10.7%	9.8%	9.6%	9.4%
Prevalence of Tube Feeding								
California	13.9%	13.5%	14.0%	14.3%	14.2%	13.9%	13.8%	13.4%
U.S.	8.5%	7.8%	7.7%	7.5%	7.2%	7.1%	6.8%	6.7%
Prevalence of Dehydration								
California	1.0%	0.5%	0.5%	0.6%	0.3%	0.3%	0.2%	0.2%
U.S.	0.9%	0.7%	0.6%	0.5%	0.4%	0.4%	0.3%	0.2%
Prevalence of Use of Daily Physical Restraints								
California	19.4%	18.3%	16.8%	14.8%	14.4%	13.5%	12.8%	10.0%
U.S.	9.3%	10.0%	9.1%	7.7%	7.1%	6.5%	5.9%	4.9%
Prevalence of Pressure Ulcers for High-Risk Residents								
California	16.2%	15.6%	15.8%	16.3%	15.5%	15.3%	15.2%	14.9%
U.S.	14.3%	15.6%	15.4%	15.6%	15.1%	14.5%	14.0%	13.4%
Prevalence of Pressure Ulcers for Low-Risk Residents								
California	4.3%	4.1%	4.5%	4.3%	4.2%	3.9%	3.4%	3.4%
U.S.	3.3%	3.4%	3.4%	3.5%	3.4%	3.1%	2.8%	2.8%

Note: Data are from the fourth quarter of each year.

The Quality of Nursing Home Care Before and After Assembly Bill 1629

Assembly Bill 1629 required the California Department of Public Health (DPH) to provide two reports assessing various indicators of the quality of patient care in nursing homes: the first report was due January 1, 2007, and covered the three years immediately prior to the passage of Assembly Bill 1629; the second report was due January 1, 2009, and covered the two years after the bill's implementation. These reports revealed the following:

- **Number of Skilled Nursing Facilities That Complied With Staffing Requirements.** The Licensing and Certification (L&C) Division within the Department of Public Health audited a random sampling of skilled nursing facilities (SNFs) for compliance with the 3.2 nursing-hours-per-resident-day requirement. (For 2002–03, 2003–04, and 2004–05, L&C audited 93 facilities. For 2005–06 and 2006–07, L&C audited 246 and 252 facilities, respectively.) L&C found that relatively few SNFs were compliant on all of the audited days; see Table A below.

Table **A**

Nursing Hours per Resident Day (NHPRD)

	2002–03	2003–04	2004–05	2005–06	2006–07
Percentage of SNFs Compliant With the NHPRD Requirement on all Audited Days	15%	20%	24%	26%	31%
Mean Average of Statewide NHPRD	3.31 hrs	3.34 hrs	3.37 hrs	3.41 hrs	3.46 hrs

Staffing Retention Rates. DPH measured retention rates by comparing the percentage of staff that was on the payroll at the beginning of a year to the percentage that was still on the payroll at the end of that year. L&C used self-reported facility data from the Office of Statewide Health Planning and Development and found that the percentage of SNFs that had a registered nurse and a licensed vocational nurse retention rate greater than or equal to 50 percent had slightly improved from 92 percent to 96 percent; see Table B below.

Table **B**

Nurse Retention Rates

		2002	2003	2004	2005	2006
Registered Nurse and Licensed Vocational Nurse	Percentage of SNFs With Retention Rates Greater Than or Equal to 50%	92%	94%	94%	95%	96%
Registered Nurse and Licensed Vocational Nurse	Percentage of SNFs With Retention Rates Between 50% to 70%	56%	52%	51%	47%	45%
Certified Nurse Assistant	Percentage of SNFs With Retention Rates Greater Than or Equal to 50%	89%	90%	92%	93%	94%
Certified Nurse Assistant	Percentage of SNFs With Retention Rates Between 50% to 70%	54%	49%	47%	45%	44%

Skilled Nursing Facilities With Findings of Immediate Jeopardy, Substandard Quality of Care, or Actual Harm Related to Federal Requirements. Although the number of skilled nursing facilities (SNFs) surveyed between 2004 and 2007 remained about the same, the number of findings of immediate jeopardy, substandard quality of care, and actual harm increased over the same period.

Immediate jeopardy is when a provider's noncompliance with one or more requirement has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. **Substandard quality of care** is when a deficiency is related to the quality of care with more than minimal harm but less than immediate jeopardy and with no "actual harm." **Actual harm** is a deficient practice that results in a negative outcome that has compromised the resident's ability to maintain or reach his or her highest level of well-being.

When L&C enters a facility and finds deficiencies or violations, it determines whether a violation is related to federal statutes and regulations (see Table C below) or state statutes and regulations (see Table D on the opposite page); because there are two separate enforcement processes for federal and state requirements, there is no causal linkage between federal enforcement and state citations.

Table C

Survey Findings of Immediate Jeopardy, Substandard Quality of Care, and Actual Harm per Federal Statutes and Regulations

Finding	2004	2005	2006	2007
Immediate Jeopardy	89	97	128	110
Substandard Quality of Care	89	90	150	129
Actual Harm	373	443	784	606
Total	551	630	1062	845
Total Number of SNFs Surveyed	1,241	1,247	1,244	1,257

Note: Data prior to 2004 is not available due to federal system constraints.

State Citations. Citations are issued when violations of state statutes and regulations occur. Typically, according to L&C, citations are issued as a result of complaints received outside of the survey process. However, citations can also be issued during the survey process if L&C determines a state regulation is stricter or more stringent than a federal statute or regulation.

Table D (see below) shows declines and increases in the number of citations issued to SNFs between 2001 and 2007. Between 2001 and 2004 the citations issued to SNFs decreased by 42 percent. According to the department, this decline may have been partially due to a shortage of L&C surveyors in the field and, as a result of the shortage, a delay of complaint investigations. In response to this shortage, the Budget Act of 2006 added more than 100 new nurse-surveyor positions and increased their salaries. Consequently, DPH says this increase in staff positions may have led to the increase in the number of state citations in 2007.

Class AA citations are for violations L&C determines have been a direct proximate cause of a patient's death. **Class A citations** are for those facilities with patients facing either an imminent danger of death, serious harm, or a substantial probability that death or serious harm could result. **Class B citations** are for violations the state determines have a direct or immediate relationship to the health, safety, or security of long-term health-care-facility patients, other than class AA or A violations.

Table **D**

State Citations per State Statutes and Regulations

Citation Class	2001	2002	2003	2004	2005	2006	2007
AA	23	9	16	11	13	12	23
A	135	144	109	73	49	96	103
B	652	590	590	384	283	400	570
Willful Material Falsification/ Willful Material Omission; Retaliation/Discrimination	3	1	3	3	1	1	2
Total	813	744	718	471	346	509	698

Average Wage and Benefits for Skilled Nursing Facility Employees. Table E (see below) shows the average hourly earnings (adjusted for inflation) for SNF staff from 2001 to 2008. Average hourly earnings for registered nurses increased (when adjusted for inflation) by about 10 percent from 2001–02 to 2007–08, whereas average hourly earnings for certified nurse assistants (when adjusted for inflation) slightly decreased.

Table **E**

Average Hourly Earnings (adjusted for inflation)

	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Registered Nurse (RN)	$24.86	$23.80	$26.10	$26.39	$26.25	$26.68	$27.47
Licensed Vocational Nurse (LVN)	$19.45	$19.98	$20.48	$20.43	$20.17	$20.33	$20.92
Certified Nurse Assistant (CNA)	$10.08	$10.14	$10.08	$9.94	$9.62	$9.72	$10.02

Efforts in Other States to Improve the Quality of Nursing Home Care

Strategies a few other states have taken to improve the quality of care provided in their nursing homes include the following:

Florida: Staff Ratio Mandates. In 1999 the Florida Legislature passed legislation that provided incentive payments to Medicaid-participating nursing homes that increased their direct-care staff. In response to these incentive payments, facilities increased wages but they substituted licensed vocational nurses for registered nurses (instead of increasing the number of direct-care staff).

For this reason, in 2001 the Florida Legislature developed a nursing home reform bill, which requires staffing mandates, tort reform, and increased regulatory oversight. These reforms include a "zero tolerance" for not meeting staffing standards; for example, they require a facility to report to the state if it is unable to meet the staffing mandates for a 24-hour period, and they impose a six-day moratorium on the admission of new residents if a facility is unable to meet staffing standards for 48 hours.

To monitor whether a nursing home meets the minimum nurse staffing levels, facilities are required to submit quarterly reports twice a year of nursing hours per resident day and staff turnover. In addition, during the nursing-home survey process, Florida inspectors review staff payroll records for the two-week period immediately prior to an annual nursing home survey and 90 days and 180 days prior to a survey.

As a result of these reforms, quality of care—as measured by improvements in nurse staffing ratios and a decline in citations—improved. In fact, Florida has the highest direct-care staffing standards in the nation (as of 2007) and its citations of "actual harm" decreased by 71 percent since the staffing mandates were implemented in 2001.

Minnesota: Pay for Performance and Bonus Payments. Minnesota is in the process of recalculating its nursing home rates to base them on actual costs (up to certain limits; for

example, 120 percent of median costs for direct care and 105 percent of median costs for other operating expenses). This rate recalculation is expected to be completely phased in in eight years, after which the spending limits will vary depending on a nursing home's quality score. The Minnesota departments of Health and Human Services created a nursing-home report card to help residents compare nursing homes based on the following seven quality measures: (1) resident satisfaction and quality of life, (2) clinical quality indicators, (3) hours of direct care, (4) staff retention, (5) use of temporary nursing staff, (6) proportion of beds in single bedrooms, and (7) state inspection results.

In 2006 and 2007 Minnesota paid bonuses to facilities with good report-card scores. The state also awards performance-incentive payments for projects, selected through a competitive process, that improve nursing-home quality or efficiency or contribute to ensuring that nursing home residents are placed in the appropriate setting. The state has found that these payments encourage additional quality improvement efforts, innovation among the providers, and the sharing of practices that could be replicated statewide.

Iowa: Bonus Payments. In 2001 Iowa introduced a point system in which Medicaid-participating facilities can obtain a bonus (up to 3 percent of median cost) if they score a sufficient number of points on a series of 10 accountability measures. During the three-year period since the system was implemented, facilities have shown a modest improvement in areas such as resident satisfaction, staffing, and employee retention.[19] However, recent newspaper investigations have revealed that the same nursing homes that were receiving bonus payments also were being fined by the state for providing poor care.[20]

What's Next?

With the passage of Assembly Bill 1629, the California Legislature intended to increase individual access to appropriate long-term-care services, improve the quality of resident care, and provide better wages and benefits for nursing home workers, a stable workforce, compliance with all applicable state and federal requirements, and administrative efficiency.

Skilled Nursing-Home Work Group

Assembly Bill 1183 (Committee on Budget, Chapter 758, Statutes of 2008) extends Assembly Bill 1629's sunset date from July 31, 2009, to July 31, 2011. Additionally, this bill required the California Department of Health Care Services to convene an 18-member stakeholder group to develop recommendations outlining how the facility rate-reimbursement system could improve the quality of resident care and ensure compliance with the intent of the bill. Of these 18 members, six were selected from consumer groups, six from skilled-nursing-facility labor groups, and six from skilled nursing facilities.

This stakeholder group met seven times in November and December of 2008 and in January 2009 for full-day meetings, which were facilitated by an independent group and supported by Department of Health Care Services staff. This work group reviewed nursing home data from various California state departments, heard presentations from experts on nursing home quality, developed more than 50 recommendations, and then voted on these recommendations. Highlights of their findings and recommendations include the following:

Consumer Groups. Representatives from consumer groups—California Advocates for Nursing Home Reform, AARP, Disability Rights California, and Ombudsman Services of Northern California—generally find that Assembly Bill 1629 has been unsuccessful in holding nursing home facilities accountable

for quality of care improvements. Consequently, their recommendations include the following:

- Repeal the labor-driven operating allocation and use that money to pay for a substantial increase in the minimum staffing requirements, including implementation of the required staff-to-patient ratios. Phase in higher staffing requirements over a four-year period. Medi-Cal does not pay profits to any other health care provider and should not do so for nursing homes. By investing these funds in increased staffing levels instead, nursing-home residents and workers will directly benefit from the state's investment. Adequate staffing is the most important factor in improving nursing home quality.

- Rate increases should be a condition of full compliance with the minimum staffing requirements. California should not be rewarding nursing homes that still fail to comply with minimum staffing standards set in 2000.

- Collect payroll data electronically on a quarterly basis to monitor staffing levels and disclose this information to the public. Under the current reporting system, the state does not learn about nursing-home staffing levels until about two years later. Quarterly electronic reporting of payroll data already maintained by nursing homes will enable the state to improve the enforcement of minimum staffing requirements, provide the public with timely and accurate information about nursing-home staffing levels, and expedite the adjustment of Medi-Cal rates.

- Require operators to increase wages and benefits annually by at least the percentage of the nursing home rate increases. A major goal of Assembly Bill 1629's higher rate requirement is to improve the quality of nursing home staff by paying decent wages and benefits, yet studies have found disproportionately small increases in both. This change would require operators to use the money for its intended purpose.

- Reduce rate increases for facilities with turnover rates above the median in their region. Thus far the Assembly Bill 1629 rate system has had relatively little impact in decreasing the very high turnover of nursing home staff, which is a leading cause of poor care. Linking rate increases to this factor will give nursing home operators a strong incentive to reduce staff turnover in their facilities.

- End the full reimbursement of liability insurance costs. Reimburse facilities for their liability insurance payments as an administrative cost subject to administrative-cost caps. Place a ceiling on liability insurance costs that is in line with the median cost within the facility's geographic peer group. Require facilities to carry liability insurance. The state should not be immunizing operators of substandard nursing homes from liability due to their negligence. Placing reasonable caps on liability insurance creates an incentive to improve care and allows the savings to be spent on staffing and resident care.

- Cap management fees paid to the parent corporations and cap the salaries of nursing home owners and their families. While resident care has not improved, nursing home profits have skyrocketed under Assembly Bill 1629. The rate system must have controls to prevent operators from using funds for corporate purposes that do not benefit residents.

- Increase the minimum staffing requirements from 3.2 to 3.5 nursing hours per resident day (NHPRD). Of this total, at least 1.0 NHPRD should be provided by licensed nurses (licensed vocational nurses or registered nurses) with no less than 0.5 NHPRD by registered nurses. Adequate staffing is the most important factor in improving nursing home quality.

- Identify goals for California's long term care system that eliminate incentives for institutionalizing people and that establish meaningful choices for consumers.

The Congress of California Seniors, another consumer organization that participated in the work group, made the following recommendations:

- Revise the labor-driven operating allocation (LDOA) by dividing it into two parts: one part for meeting state staffing standards and the other for staffing at levels above the minimum standards. The LDOA should be more directly tied to improving staffing levels.

- Create a new minimum-staffing standard for registered nurses in nursing homes. Research indicates that the presence of registered nurses raises the level of quality care in nursing homes.

- Increase the percentile cap for direct-patient-care staff to create an incentive to increase wages and benefits. The current rate methodology provides for reimbursement of actual spending on direct patient care up to the 90th percentile of a facility's geographic peer-group spending for that purpose.

- Adjust the reimbursement methodology and reporting requirements for liability insurance. Because paying for liability insurance cuts into funds available for patient care, the quality of care could be better financed if liability insurance costs were held down.

- Adjust the reimbursement methodology and reporting requirements for costs associated with transitioning patients to community-based care. Identifying and reporting on the costs associated with these transitions will raise the awareness of facilities, policy makers, and the public about the degree of compliance with this high state priority. (Following a U.S. Supreme Court decision, known as the *Olmstead* decision,[21] California has established a high priority on the provision of non-institutional long-term-care services, that is, community-based services for people with disabilities.)

- Shorten the lag time between facility expenditures and Medi-Cal reimbursement rate adjustments.

Currently, a facility must wait two years to recover the costs associated with salary adjustments, additional staff, or higher non-labor expenses in their rates. This lag time is a result of the state's current procedure for collecting and verifying data.

- Measure and report on the impact of the universal cap on Medi-Cal rates. Assembly Bill 1629 includes a provision that caps the total increase in reimbursements to skilled nursing facilities from one year to the next. Research evaluating the impact of the cap on patient care, institutions, and the patient population should be conducted.

- Develop a system for defining, collecting, and reporting on the quality-of-care and quality-of-life data acquired from skilled nursing facilities. The work group concluded there is not enough data to effectively monitor the quality of care and life in California's nursing homes (agreement on how to appropriately measure this data also is needed).

Labor Groups. Although nurse staffing levels have risen slowly since Assembly Bill 1629 passed, SEIU has found that too few nursing homes have taken advantage of the new system to make significant improvements in staffing and compensation. Consequently, SEIU's recommendations include the following:

- Enact clear enforceable penalties for staffing below the minimum staffing standards—such as an automatic B citation (see "State Citations" on page 29 for citation descriptions)—when a nursing home is staffed below the required threshold.

- Improve the enforcement of staffing requirements. The state should require payroll-data reporting, which would help enforce staffing requirements, and timelier labor-cost reporting into the rate system, which would help prevent delays in Medi-Cal's acknowledgment of a facility's increased costs.

- Modify the labor-driven operating allocation (LDOA) to increase incentives

for better staffing. A part of the LDOA would be contingent on a facility meeting the state's minimum staffing requirements. Another part would rise in relation to a facility's staffing: the higher the nursing hours per resident day, the higher the LDOA.

- Develop a program to evaluate turnover and retention issues in nursing home staff. Nursing homes that do not improve working conditions that could decrease turnover rates should be penalized, and high-performing nursing homes should be rewarded financially.

- Reimburse liability insurance costs through the administrative cost center, where it would be subject to the 50th percentile cap. (Liability insurance is currently fully reimbursed.) There should be reasonable cost controls on facility reimbursements for insurance costs; this could encourage better care and working conditions that would in turn lower liability insurance claims and costs.

- Reimburse *Olmstead* implementation costs separately from other costs and increase efforts to return nursing home residents to home- and community-based settings. Costs incurred in assisting residents in transferring to the community (*Olmstead* costs) should be fully reimbursed to encourage providers to make greater efforts in this area. Additionally, California should do more to enable community living by developing nursing-home transition programs and expanding and strengthening existing programs.

- Encourage facilities to provide more training. Better training results in a more satisfied and productive workforce and improves the quality of care. The state and interested stakeholders should work to identify ways to encourage more training and reimburse facilities for the cost of these trainings.

- Redesign the cost reports to collect additional relevant information that will assist with the nursing-home rate-setting process and the analyses on how this

impacts the Medi-Cal reimbursement system.

SEIU sponsored Senate Bill 434 (Romero) in the 2007–08 legislative session (as amended on July 14, 2008),[22] which would have required nursing homes to submit payroll data quarterly to the Department of Health Care Services because, according to SEIU, the department could use this information to reimburse facilities more quickly for their increased spending on staff.

Nursing Homes. In contrast to the findings of consumer and labor groups, nursing homes, as represented by the California Association of Health Facilities, Aging Services of California, Country Villa Health Services, and SnF [*sic*] Management, have found that Assembly Bill 1629 has had a positive impact and has increased nursing home accountability by bringing reimbursements more in synch with individual facility costs. They agree, however, that improvements could be made, including the following:

- Shorten the time required to recognize new costs so adequate resources are available to adjust for appropriate changes in a provider's spending. The 18- to 30-month delay between facility spending and the recognition of those costs in the rate methodology constrains a facility's ability to increase spending on wages and benefits.

- Discontinue the process of continuing to extend Assembly Bill 1629's sunset date and make the reimbursement system permanent. The uncertainty over the successful continuation of Assembly Bill 1629's payment methodology undermines provider confidence that long-term funding will be stable.

- Improve and update the cost reporting process, which is fractured, creating problems with cost-validation and rate-setting processes. (Currently, nursing homes must submit a cost report to OSHPD; however, this cost report does not provide the details necessary for DHCS to calculate Assembly Bill 1629's rates, and nursing homes are required to submit supplemental cost information to DHCS.)

- Clarify cost-component elements and definitions to mitigate disagreements over cost categorizations, generate accurate rates, and avoid unnecessary appeals. Disagreements between providers and DHCS staff over Assembly Bill 1629's cost-component categorizations have led to incorrect rate determinations and audit appeals.

- Consider fully reimbursing costs associated with improving resident quality of care and safety, as well as workforce safety and general working conditions. The investment in medical-care information technology (such as electronic medical records and e-prescribing), the replacement of old resident beds with new electric models, and the training of personnel who can directly impact the quality of resident care and services will benefit resident care and improve worker safety and working conditions. Fully reimbursing these costs would encourage providers to make these investments.

- Increase the reimbursement rate to 100 percent of costs for registered nurse (RN) direct-care staffing and gerontological nurse practitioner (GNP) services in nursing homes. Research shows a correlation between increased RN staffing levels, tenure in nursing homes, and better resident outcomes. Increasing the reimbursement rate would establish an incentive for providers to employ and retain RNs and GNPs.

- Consider establishing a combined rate-review and audit-appeals process. Currently there is no formal rate-review process and the existing audit-appeals process is labor- and cost-intensive for both nursing homes and the Department of Health Care Services. Consideration should be given to combining these tasks, which could result in savings.

- Review the impact of current cost-component caps. Assembly Bill 1629's cost caps were developed based on factors designed to offer incentives for allocating money to particular categories, such as labor, and to control general

costs, such as administrative expenses. Given that Assembly Bill 1629 has been in place for more than three years, the Department of Health Care Services and interested stakeholders should review whether the impact and effectiveness of the current cost-component caps meets the intent of the bill's creators.

- Develop a uniform data-collection system and a reliable mechanism to obtain nursing-home resident, family, and staff satisfaction measures. Quality of life measurements, such as resident satisfaction, are not currently collected and measured. Satisfaction surveys offer an important barometer to providers seeking to improve the quality of their facilities.

- Review the fair rental value system (FRVS) cost component to evaluate its effectiveness. Consideration should be given to rates that recognize and support allowable capital investment in projects, equipment purchases, facility improvements, and other infrastructure. The FRVS rate component (designed to reimburse a provider for capital costs and upgrades) has not sufficiently encouraged providers to improve infrastructure or purchase new equipment.

The California Department of Health Care Services' Report. The Department of Health Care Services is required to submit a report to the California Legislature by March 1, 2009, that presents all stakeholder recommendations and the department's analysis of the feasibility of implementing the proposed recommendations.

Appendix

California Assembly Bill 1629: Estimated Impact to the General Fund[A]

(fiscal years/dollars in thousands)

Reimbursement to Facilities	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	5-Year Total[B]
Prior System[C]	$2,644,289	$2,716,442	$3,038,026	$3,144,357	$3,254,409	$3,368,314	$15,521,548
Assembly Bill 1629 Rate[D]	$2,644,289	$2,956,722	$3,314,008	$3,390,420	$3,497,500	$3,668,878	$16,827,528
Assembly Bill 1629 Quality Assurance Fee (QAF)[E]	Not in effect	($115,600)	($231,893)	($247,406)	($274,300)	($289,387)	($1,158,586)
Net Assembly Bill 1629	Not in effect	$2,841,122	$3,082,115	$3,143,014	$3,223,200	$3,379,491	$15,668,942
Net Increase to Facilities	Not in effect	$124,680	$44,089	($1,343)	($31,209)	$11,177	$147,394
General Fund Increase/(Decrease)[F]	Not applicable	$4,540	($93,902)	($124,374)	($152,755)	($139,105)	($505,596)

[A] Estimated by the California Department of Health Care Services (DHCS). Unless otherwise noted, data were updated by DHCS in March 2008.

[B] From fiscal year 2004-05 to fiscal year 2008-09.

[C] Increase projected at 3.5 percent per year after fiscal year 2005-06.

[D] Fiscal years (FY) 2005-06 through 2007-08 from DHCS, Summary of Estimated Fiscal Impact by Rate Year; FY 2008-09 projected as a 4.9 percent increase from FY 2007-08.

[E] From DHCS, 2007-08 Long Term Care Rates and Budget, Summary Budget Calculations—Long Term Care Facilities, except assumes a 100 percent collection of QAF.

[F] Fifty percent of the remainder of Net Increase to Facilities, less Assembly Bill 1629 QAF.

Endnotes

1 California Health and Safety Code, Section 1250(c).

2 Charlene Harrington, PhD, RN, and Janis O'Meara, MPA, "Snapshot: The Changing Face of California's Nursing Home Industry," California HealthCare Foundation, March 2007, p. 3.

3 Ibid.

4 *Improving the Quality of Long Term Care*, Institute of Medicine (Washington, D.C., National Academy Press, 2001), p. 12.

5 Mary Bliesmer, Miles Smayling, Robert Kane, and Iris Shannon, "The Relationship Between Nursing Staffing Levels and Nursing Home Outcomes," *Journal of Aging and Health*, vol. 10, no. 3, August 1998, p. 363.

6 John Capitman, PhD, and Christine Bishop, PhD, "Long-Term Care Quality: Historical Overview and Current Initiatives," National Quality Forum, 2005.

7 Medicare, The Official U.S. Government Site for People With Medicare, www.medicare.gov.

8 "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes," Abt Associates, Inc., report to Congress: phase ii final, vol. i-iii, 2001, commissioned by the U.S. Centers for Medicare and Medicaid Services.

9 Nicholas Castle, PhD; John Engberg, PhD; and Aiju Men, MS, "Nursing Home Staff Turnover: Impact on Nursing-Home Compare Quality Measures," *The Gerontologist*, vol. 47, no. 5, October 2007.

10 Charlene Harrington, PhD, RN; J.T. Mullan; and H. Carrillo, "State Nursing Home Enforcement Systems," *Journal of Health Politics*, *Policy, and Law,* vol. 29 (1), p. 43-73.

11 Charlene Harrington, PhD, RN; Janis O'Meara, MPA; Eric Collier, PhD, RN; Taewoon Kang, PhD; Caroline Stephens, MS, RN; and Jamie Chang, MA, "Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality, and Costs," University of California, San Francisco, April 1, 2008, p. 12.

12 California Department of Public Health, Health Facilities Consumer Information System, http://hfcis.cdph.ca.gov/default.aspx.

[13] *Improving the Quality of Long Term Care*, Institute of Medicine, p. 79-91.

[14] Greg Arling, PhD; Robert Kane, MD; Teresa Lewis, BA; and Christine Mueller, RN, "Future Development of Nursing Home Quality Indicators," *The Gerontologist*, vol. 45, no. 2, February 2007.

[15] "Nursing Staff Requirements and the Quality of Nursing Home Care," Department of Health Services' Licensing and Certification Program, 2001, p. 23.

[16] "California Nursing Homes' Care Problems Persist Despite Federal and State Oversight," U.S. General Accountability Office, July 1998, p. 7-27.

[17] Ibid.

[18] Charlene Harrington, PhD, RN, et al., "Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality, and Costs," University of California, San Francisco, April 1, 2008. John Schnelle, PhD; Dana Mukamel, PhD; Hui-Win Sato, MS; and Jenny Chang, MPH, "Evaluation of AB 1629," 2008.

[19] Robert Kane, MD; Greg Arling, PhD; Christine Mueller, PhD, RN; Robert Held, MBA; and Valerie Cook, "A Quality Based Payment Strategy for Nursing Home Care in Minnesota," *The Gerontologist*, vol. 47, no. 1, February 2007, p. 110.

[20] Clark Kauffman, "State Pays Bonuses to Worst of Homes," *Des Moines Register*, March 2, 2008.

[21] Olmstead v. L. C. Zimring, 527 U.S. 581 (1999).

[22] Senate Bill 434 was held in the Senate Rules Committee. The original version of the bill addressed a different topic.

California Senate Office of Research

Established in 1969 by the Senate Rules Committee, the California Senate Office of Research is a nonpartisan office charged with serving the research needs of the California State Senate and helping with the development of policy for Senate members and committees. For more information and copies of this report, please visit www.sen.ca.gov/sor.

Michelle Baass

Michelle Baass specializes in public health. Before joining the California Senate Office of Research in early 2008, she was a public health and environmental protection analyst for the Legislative Analyst's Office for four years. Prior to that she worked for Accenture as an information systems consultant and a manager in the government practice.

1439-S
Additional copies of this publication may be purchased for $8.50 per copy
(includes shipping and handling), **plus current California sales tax**.

Senate Publications & Flags
1020 N Street, B-53
Sacramento, CA 95814
(916) 651-1538

Make check or money order payable to **Senate Rules Committee**.
Credit cards not accepted.
Please include Stock Number 1439-S when ordering.