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.

- ÊDevelop 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.

- ÊReview 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.

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