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California Department of Health Care Services
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RE: Public Comments on AB-186 Nursing Facility Financing Reform

Dear Lindy, Laura, and Alek,

This letter is a response to your request for public comments on DHCS's progress on nursing facility financing reforms under AB-186 following your 2nd Stakeholder Meeting on November 18, 2022.

I am writing you on behalf of the California Long-Term Care Ombudsman Association (CLTCOA), a membership organization comprised of local Long-Term Care Ombudsmen, their staff, and volunteers. The state and federally-mandated purpose of the Long-Term Care (LTC) Ombudsman Program is to ensure the highest possible quality of life and care for older adults and adults with disabilities living in skilled nursing facilities (SNFs) and residential care facilities for the elderly (RCFEs). The program provides regular, unannounced in-person facility monitoring visits and resident-centered advocacy conducted by State-certified Ombudsman representatives. These advocates identify and resolve complaints and ensure that facilities are free from health and safety issues.

We appreciate your understanding of the varied and complex care issues affecting the most vulnerable. We acknowledge your agency's ongoing commitment to serve older adults and adults with disabilities who receive care in California's 1,200+ skilled nursing facilities. And we recognize the difficult task to which you are endeavoring, addressing the financial stability of skilled nursing facilities while ensuring the safety and security are our most frail Californians, is especially crucial during the COVID-19 pandemic.

Since the introduction of the Quality and Accountability Supplemental Payment (QASP) program, LTC Ombudsman Advocates have been supportive of the goals and the legislative intent of AB-186. The QASP program was created to utilize matching federal funds to reward SNFs that provide quality resident care. However, despite these good intentions, the current program has not produced meaningful improvements in these facilities as highlighted in several

studies, discussed in numerous legislative policy hearings, and reflected in the first-hand accounts of residents and the local LTC Ombudsman representatives.

As the advocates focused on quality of care and quality of life for long-term care residents, we're writing you again to provide constructive feedback on DHCS's re-design of the SNF Quality and Accountability Supplemental Payment (QASP) system thus far. **CLTCOA is certainly encouraged by DHCS's increased focuses on staffing metrics – which now accounts for 50% of each facilities' total score under the proposed program – as well as providing incentives to facilities that serve a greater proportion of Medi-Cal patients.** However, we feel there are still several facets of the program that could be further clarified or revised to ensure that high quality care is being provided to all eligible Californians in line with DHCS's Comprehensive Quality Strategy:

1. Ensure that ongoing funding for the Long Term Care Ombudsman Program provided under the former law is not subsumed by the General Fund under AB-186;
2. Ensure that Long Term Care Ombudsmen will be part of any future conversations about how funding previously collected through the Skilled Nursing Facility Quality and Accountability Special Fund will be spent or allocated going forward under the new WQIP payment collection and distribution mechanisms;
3. Clarify how much additional funding each SNF is expected to receive annually on average given that $244.9 million in additional funding will be distributed through the new WQIP next year;
4. Only provide financial incentives based on staffing hours for facilities that are meeting or exceeding the minimum legal requirements for staffing;
5. Revise the staff turnover metric so that turnover for clinical vs. non-clinical staff is tracked because the former is far more relevant to residents' quality of life;
6. Do not differentiate between weekday vs. weekend hours for minimum staffing requirements because residents have the same staffing needs on weekdays as they do on weekends;
7. Add additional MDS or claims-based metrics to ensure that the claims-based metrics proposed are not artificially lowered by facilities seeking higher WQIP payments under the new system;
8. Clarify how many metrics may be "suppressed" for a given SNF and how those points will be re-allocated to other areas if a SNF fails to provide data for several metrics;
9. Eliminate or reduce the point values for the Racial & Ethnic Data Completeness Metric to avoid inaccurate self-reporting by SNFs;
10. Increase the weight of the Disproportionate Share Metric to account for the fact that SNFs continue to prioritize Medicare patients over Medi-Cal patients so long as it remains more profitable for them to do so on a per-resident basis;
11. Clarify how regularly SNFs will report PBJ, MDS, and other data to DHCS to participate in the new WQIP system: annually, quarterly, or monthly; and
12. Clarify what accountability measures will be taken if SNFs fail to meet minimum legal requirements in terms of staffing hours or other metrics and how those processes interface with the new WQIP system.

A more detailed explanation for each recommendation is provided below for your consideration. I'm happy to discuss any of our comments with you further. You can find my contact information listed below.

Funding for LTC Ombudsman Programs

One of the primary goals of the current QASP program is to "provide funding assistance for the Long-Term Care Ombudsman Program activities" under WIC § 14126.022. The local LTC Ombudsman programs we represent receive a combined $1.9 million in funding from Quality Assurance Fees (QAFs) annually (not accounting for inflation) through the Skilled Nursing Facility Quality and Accountability Special Fund, which accounts for 12.8% of the Department of Aging's combined budget for all local LTC Ombudsman Programs across the state next fiscal year. WIC § 14126.022 also explicitly states that it was the "intent of the Legislature to increase this level of appropriation in subsequent years to provide support sufficient to carry out the mandates and activities [of the LTC Ombudsman Program]" when the statute was enacted. The appropriation has remained $1.9 million in every subsequent year since those amendments were passed in 2010-2011 even though inflation has incrementally reduced the value of the dollar by over 30% during that same timeframe. It is one of few sources of ongoing funding remaining for the LTC Ombudsman program, which again is mandated by the federal government under the Older Americans Act.

AB-186 states: "Existing law extends the department's use of the Skilled Nursing Facility Quality and Accountability Special Fund to December 31, 2022, and ceases the availability of those payments on January 1, 2023. Under existing law, the rate methodology becomes inoperative after December 31, 2022, and these provisions will be repealed on January 1, 2024." Funding that would be distributed to LTC Ombudsman programs through the Special Fund will therefore be distributed from the General Fund going forward since AB-186 does not create a new fund for the WQIP. Yet, from prior experience during periods of recession, CLTCOA understands that any funds within the General Fund earmarked for other purposes can be reallocated in times of crisis.

Therefore CLTCOA seeks to clarify whether the proposed system would still ensure that at least $1.9 million from the Special Fund would still be allocated to the LTC Ombudsman Programs annually per WIC § 14126.022 under the new WQIP, with the potential for this amount to increase in subsequent years as the Code requires. We interpret the amendments to WIF §14126.022 of the Welfare and Institutions Code in Section 7 of AB-186 as a sort of hold harmless provision for funding for LTC Ombudsman programs. The facts that the Special Fund will be abolished and the payment mechanisms for the new WQIP will therefore change does not appear to impact or preclude continued funding for LTC Ombudsman programs under AB-186.

Finally, CLTCOA requests that DHCS and other stakeholders consult with the Office of the State Long Term Care Ombudsman, CLTCOA, and local LTC Ombudsmen offices in regards to any future conversation about re-allocating the $1.9 million+ currently allocated to the LTC Ombudsman Program to other government programs or initiatives in the future. Long Term Care Ombudsmen are monitoring SNFs the most frequently compared to other agencies or programs within the larger consumer protection and enforcement system for SNFs, so LTC Ombudsmen

play a critical role in assuring and confirming the success of the new WQIP proposed by DHCS. Without this funding, LTC Ombudsmen programs would not be able to visit facilities, investigate complaints, and resolve disputes with the same frequency and attention to detail, and many of these issues stem from the same concerns that the WQIP is seeking to address through providing incentive payments to SNFs.

Increased Payments to SNFs

AB-186 states that $280 million will be allocated to WQIP payments to SNFs annually in CY 2023 and 2024 According to the 2022 April QASP Payment Annual Report published by DHCS, only $35.1 million was distributed to SNFs through the former QSAP program last year with the average payment to each facility being between $55,765.43 and $93,035.82. This means SNFs can expect to cumulatively receive $244.9 million more funding next year under the new WQIP.

CLTCOA assumes that DHCS has based its new scoring systems on calculations that would provide SNFs with at least or approximately as much funding as they previously received under the QASP system – and likely more due to the increase of total available funding per AB-186 – to ensure SNFs can budget consistently from year to year as DHCS continues to design and implement the new WQIP system. How much does DHCS expect each SNF to receive under the new WQIP according to data submitted through the former QASP system? Assuming there are 1,200 licensed SNFs eligible to participate in the WQIP in California, CLTCOA would expect the average facility to receive closer to $233,333.33 annually. This means the payments to SNFs through the WQIP would likely double or triple over the coming years.

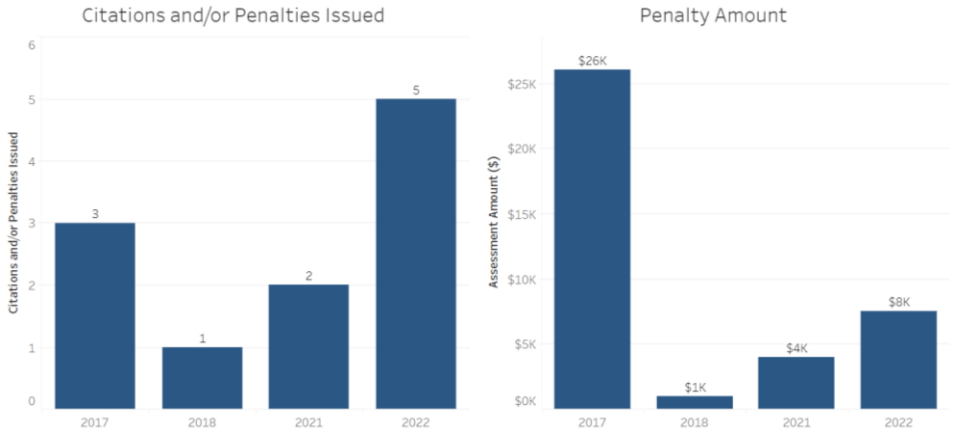
While CLTCOA recognizes that continuity of such payments is important to SNF's abilities to budget, we note that higher payments should be accompanied by higher standards of care if the ultimate goal of the WQIP is still to continue improving substandard conditions for residents of SNFs across the state. Otherwise, the WQIP does not serve to incentivize the SNF industry but subsidize their continued poor performance by rolling incentive payments into the anticipated baseline for the new program. The $280 million in taxpayer money allocated to the WQIP should be used to fund initiatives that lead to a demonstrated increase in the quality of care for the 400,000+ Californians who live in such facilities over the next several years as AB-186 requires.

Staffing-Based Metrics

Under the proposed scoring system, payments would be made to facilities that do not meet the current minimum requirements for staffing in SNFs according to CDPH, which is currently 3.5 direct care service hours per patient day with CNAs performing a minimum of 2.4 hours per patient day. The proposed system would seemingly award up to 1-3 points to facilities that fail to meet the 2.4 hours per patient day by CNA requirement regardless of whether those facilities were granted waivers/exceptions to those workforce requirements by CDPH. By awarding any points to facilities falling under this minimum threshold, DHCS would financially rewarding facilities that do not meet the most basic staffing requirements under California law. Doing so would be antithetical to the DHCS's and CMS's commitments to making continued progress towards improving the quality of care in SNFs. Accordingly, CLTCOA recommends that no points be awarded to facilities that would fall under the current 50th percentile for staffing hours

for CNAs – which is currently around 2.43 hours per patient day – since that nearly represents the bottom-line staffing requirements for CNAs in SNFs. Instead, points should only be distributed to facilities within the 50th-100th percentiles for staffing in proportion to their staffing levels to encourage non-conforming facilities to come up to reach the minimum legal requirements for CNA staffing hours.

While WIC § 14126.022(e) authorizes the CDPH to impose an "administrative penalty if [CDPH] determines that the skilled nursing facility fails to meet the nursing hours or direct care service hours per patient per day," CDPH's Center For Health Care Quality's own State Enforcement Actions Dashboard indicates that CDPH only issued 11 citations to SNFs based solely on staffing since 2015. Unless the metrics that DHCS will track under the proposed system are provided to CDPH for CDPH to routinely cite non-conforming facilities, then facilities not meeting minimum staffing requirements would still ultimately receive a net benefit from the WQIP payments from DHCS under the proposed scoring system.



How will DHCS work with CDPH and other agencies to ensure that facilities are cited when they fail to meet those legal standards as demonstrated by data collected through the new WQIP? Will DHCS and CDPH share data for these purposes, or will DHCS make referrals to CDPH when a facility falls under the minimum legal limit in an area such as staffing? This relates to our questions about "accountability sanctions" under AB-186, discussed below.

Lastly, CLTCOA is concerned that the proposed metric for staff retention is not robust or detailed enough to lead to higher-quality outcomes in that area because it appears to focus on facilities' average retention rate for all staff and not just the retention of the clinical staff crucial to providing care in SNFs such as MDs, LVNs, CNAs, and so forth. Turnover among administrative and other non-clinical support staff is clearly not as relevant to the continued quality of personalized care that residents receive on a day-to-day basis from the doctors, nurses, and aids knowledgeable about those patients' diagnoses, interventions, habits, and personalities Accordingly, CLTCOA would like DCHS to clarify whether both a SNF's clinical and administrative/other staff will be counted towards this measure or if just clinical staff will be considered.

Claims-based Clinical Metrics

Under the proposed system, points would be awarded to facilities based on the total number of reported emergency room visits per 1,000 long-stay resident days by residents in their care. CLTCOA worries that utilizing such a basic metric would ultimately discourage facility staff from taking residents to the emergency room. Doing so would decrease facilities' total numbers of ER visits and therefore increase the per diem payment amounts they receive for each resident under the proposed system. Additional metrics should be considered to ensure that facilities cannot artificially lower their number of emergency room visits per 1,000 long-stay resident days by refusing or waiting to take residents to the emergency room when appropriate or needed.

Similarly, the proposed system would award points to facilities based on their total number of healthcare-associated infections requiring hospitalization among their residents. "The hospitalization must occur during the period beginning on day four after SNF admission and within three days after SNF discharge" according to CMS. Utilizing this metric as an indirect measure of the quality of care during a resident's long-term stay may discourage facilities from noticing or treating early signs of infections – especially among residents scheduled to be discharged in the near future – to reduce their total number of healthcare-associated infections and again increase their per diem payments.

While CMS's Potentially Preventable 30-Day Post-Discharge Readmissions Metric would theoretically indicate poor health outcomes caused by facilities failing to hospitalize or otherwise treat their residents soon enough, that metric also appears to be subject to the same loophole: facilities can avoid reporting by waiting more than 30 days to re-admit residents following their initial discharge.

Equity-Based Metrics

CLTCOA is pleased to see the inclusion of equity-based metrics in the proposed WQIP.

However, the Racial & Ethnic Data Completeness Metric is based solely on facilities providing DHCS & CDPH with detailed demographic information that these facilities self-report, which is difficult to audit or confirm without access to each individual resident and is therefore inherently unreliable. Our concern is that connecting SNF's quality improvement *payments* simply to the *reporting* of such demographic information may encourage facilities to collect or estimate this data without sufficient involvement of residents, potentially collapsing or ignoring racial and ethnographic categories in ways that distort the overall picture of those facilities' demographics and ultimately work against DHCS' efforts to obtain more accurate demographic data from SNFs going forward. At the very least CLTCOA would recommend that data gathered using this metric be compared to demographic data from the U.S. Census in each facility's region to ensure that facilities are making meaningful efforts towards promoting diversity and inclusion in terms of representing the communities in which they are located.

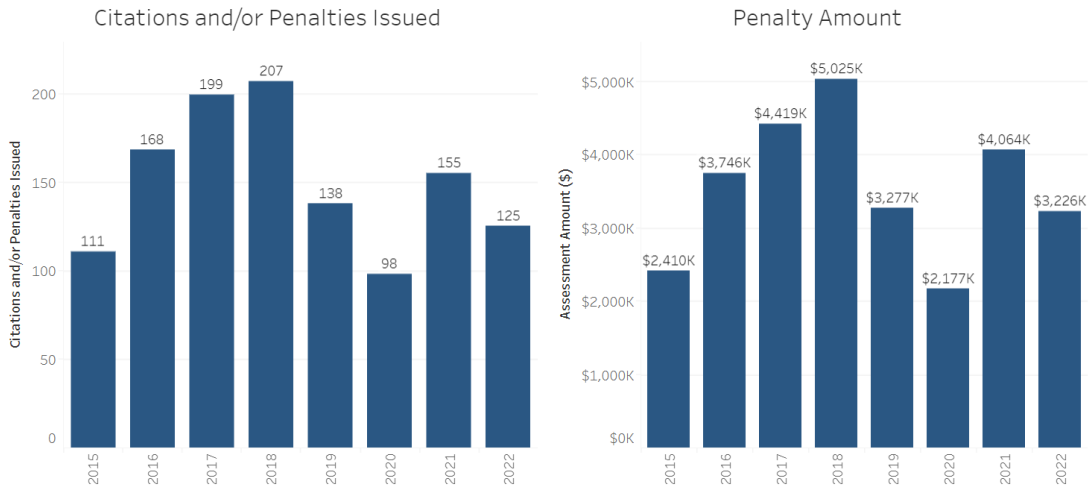
While CLTCOA is also encouraged by the addition of a Disproportionate Share Metric, which award points to facilities that have a share of Medi-Cal patients above the 50th percentile in their peer group, we are concerned that the proposed scoring system will not necessarily trend towards improvement. By definition, a facility's ratio of Medi-Cal patients is only compared against the ratio of Medi-Cal patients in other SNFs and not against a defined goal or measure of

improvement from DHCS and CDPH. This metric effectively awards 1-5 points to facilities based on whether they fall above the state median in proportion to the percentage of Medi-Cal patients they have over other SNFs above the median. Since long-term health care advocates like CLTCOA generally agree there is a bias against Medi-Cal patients in SNFs in California that results in fewer Medi-Cal patients residing in SNFs than what is needed overall, the proposed scoring system will trend towards maintaining the status quo if it continues to be far more profitable for SNFs to provide care to Medicare patients. It's doubtful that nominal increase in points, and therefore funding, provided by DCHS to facilities making marginal improvements compared to their peers under the proposed program will be enough to mathematically offset the profits and other benefits SNFs receive by refusing Medi-Cal patients in favor of Medicare patients.

Accountability Components

In DHCS's first Stakeholder Meeting on October 25, 2022, you stated that "accountability sanctions" would be part of the new system that DCHS is developing. What specific accountability measures will DHCS be taking against SNFs that do not meet basic legal requirements, and how will other agencies like CDPH be involved in the process? No additional information has been provided on this topic by DHCS yet. CLTCOA would hope that citations would be issued to facilities that do not meet the basic legal requirements for operating a SNF.

Furthermore, CLTCOA finds DCHS's plan to only exclude facilities that have been "issued" A or AA citations from the new WQIP payments concerning. According to the State Enforcement Actions Dashboard, only 495 unique SNFs were issued A or AA citations for long term care since 2015. However, according to the California Association of Health Facilities (CAHF), "There are approximately 1,230 licensed long-term care nursing facilities in California. These include free-standing nursing homes and 'distinct part' nursing homes which are attached to hospitals." Class B citations were issued to 1,058 unique facilities – nearly all SNFs in California – during that same timeframe according to the Dashboard. This indicates that while most SNFs do receive some sort of citation over a 5-year period, those infractions are often not considered serious enough to warrant an A or AA citation.



DHCS's focus on A and AA citations in this context is both confusing and limiting. CDPH, which is responsible for issuing citations to SNFs, ranks their enforcement actions from class A to class C in terms of severity, with AA being the most serious. In contrast, CMS uses the Scope & Severity Matrix below to classify federal-level enforcement actions, with J being the most serious. The federal-level citations and deficiencies are accompanied by an "F-Tag" which indicates the exact nature(s) of the violation(s).

Severity	Scope		
	Isolated	**Pattern**	**Widespread**
Level 4 **Immediate jeopardy to resident health or safety**	**J** Plan of Correction Required: Category 3 Optional: Category 1 Optional: Category 2	**K** Plan of Correction Required: Category 3 Optional: Category 1 Optional: Category 2	**L** Plan of Correction Required: Category 3 Optional: Category 1 Optional: Category 2
Level 3 **Actual harm that is not immediate jeopardy**	**G** Plan of Correction Required: Category 2 Optional: Category 1 Optional: Termination	**H** Plan of Correction Required: Category 2 Optional: Category 1 Optional: Termination	**I** Plan of Correction Required: Category 2 Optional: Category 1 Optional: Temporary Management Optional: Termination
Level 2 **No actual harm with potential for more than minimal harm that is not immediate jeopardy**	**D** Plan of Correction Required: Category 1 Optional: Category 2 Optional: Termination	**E** Plan of Correction Required: Category 1 Optional: Category 2 Optional: Termination	**F** Plan of Correction Required: Category 2 Optional: Category 1 Optional: Termination
Level 1 **No actual harm with potential for minimal harm**	**A** No Plan of Correction No remedies Commitment to Correct Not on CMS-2567	**B** Plan of Correction	**C** Plan of Correction
A, B, C: Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm (42 CFR §488.301). **J, K, L, H, I, F**: Substandard quality of care is any deficiency in 42 CFR §483.13, Resident Behavior and Facility Practices, 42 CFR §483.15, Quality of Life, or 42 CFR §483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.			

State-certified Long Term Care Ombudsmen working in the field have observed that state-level citations issued by local CDPH offices often cite the federal classification system (i.e., Scope & Severity Matrix) and F-tags when documenting violations and not the state classification system. To the extent that some state-level enforcement actions are not being assigned an associated state-level classification for this reason, CLTCOA worries that such enforcement actions will not be counted against SNFs under DHCS's proposed changes to the WQIP. State-level enforcement actions citing the Scope & Severity Matrix and F-tags instead of the state-level classification system should also be included in DCHS's accountability measures for the WQIP.

CLTCOA recommends that facilities receiving citations more serious than level "G" under the federal system (i.e., J, K, L, H, & I) in a given year also be excluded from receiving WQIP payments. These federal citations are at least as serious as the A and AA citations issued by CDPH, if not more so. Citing both federal and state classifications would prevent SNFs from remaining eligible for WQIP payments following a serious violation despite how they are currently classified by the state internally. Doing so would also be in line with DHCS's goal to bring the new WQIP system more in line with CMS's data collection and reporting protocols.

Furthermore, because the Long Term Care Ombudsman Program is the only government entity dedicated to sending individuals into SNFs to personally or physically living conditions on a regular (more than annual or semi-annual) basis, CLTCOA advises DHCS to meet with Long

Term Care Ombudsmen on a regular/consistent basis to discuss the effectiveness of the new WQIP program. Having conversations with LTC Ombudsmen about what they are *actually seeing* in participating SNFs they visit a monthly or quarterly basis could bring a critical qualitative perspective to the otherwise quantitative data-heavy WQIP. Such observations from LTC Ombudsman could serve to confirm and even bolster narratives based on the data DHCS is collecting for the WQIP. They could also identify areas where more data collection or analysis is needed as DHCS continues to design and refine the new WQIP system over the coming years.

Reporting & Metric Suppression

At the first Stakeholder Meeting on October 25, your team stated that "DHCS proposes to use a July 1, 2022 through June 30, 2023 performance period for most metrics, aligned with the former QASP program." However, at the second Stakeholder Meeting on November 18, your team provided the following table of "measurement periods" for each category of data being considered by DHCS: PBJ-based, MDS-based, and claims-based. The "measurement periods" do not seem to align with the "performance period" though. Does this mean that historical PBJ and claims-based data would always be used to calculate a facility's total score for a given year?

Metric Data Source	Measurement Period	Measurement Population
Minimum Data Set (MDS)	July 1, 2022 to June 30, 2023	All patients
Claims-based	January 1, 2023 to December 31, 2023	Patients enrolled in Medi-Cal managed care, including Medi-Cal/Medicare Dual-eligible members
Payroll Based Journal (PBJ)	April 1, 2023 to September 30, 2023	All direct care staff

CLTCOA also asks DHCS to clarify how often facilities need to report within each measurement or performance period. Are facilities providing data for the WQIP to DHCS on an annual, quarterly, or monthly basis?

Additionally, at the second Stakeholder Meeting, DCHS stated the following about "Metric Suppression:"

> *If DHCS is unable to score a metric for a facility because the facility did not have any reportable data or did not meet the metric's minimum denominator size threshold, then the metric will be suppressed for that facility. When a metric is suppressed, points for that metric will be reallocated equally across the other metrics in the same measurement area or domain*

Will DHCS set a limit on how many metrics can be "suppressed" for a facility in each performance or reporting period? CLTCOA is concerned that facilities may intentionally fail to report certain metrics so that those metrics do not count against them under the new WQIP system to boost the point values of the metrics where that facility is meeting or exceeding expectations, therefore increasing their total WQIP payments despite poor performance in a particular area. To illustrate this point, if a facility only reported data for a single metric under the new WQIP and then received 100% of the points in that category, would DCHS then award

them 100% of the total available points under the new WQIP system? This appears to create a loophole that SNFs can exploit for more funding by simply withholding data from DHCS in a given reporting or performance period.

Conclusion & Closing Remarks

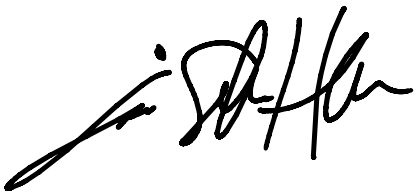
In our last letter to DHCS dated March 28th, 2022, CLTCOA urged DHCS to make bold, meaningful changes to the QASP. The current system offers little assurance that facilities will provide better care or increase compliance with state and federal protocols because it is often far too easy for facilities to meet those standards. For example, nearly all facilities received points for the current Influenza Vaccination (Long Stay) Quality Measure because SNFs were already required to vaccinate their residents against influenza at the time of reporting. Offering any direct financial incentives to facilities for merely meeting minimum or baseline requirements does not demonstrate the type of commitment to quality improvement in the SNF industry that AB-186 demands and LTC resident advocates expect.

The reforms occasioned by AB-186 are an opportunity for DCHS to completely reenvision the delivery of skilled nursing care in California. CLTCOA hopes that DCHS is willing to consider including additional metrics or expanding on those proposed so far to provide SNF staff, LTC advocates, and regulators with the essential data and additional accountability needed to promote better overall health care outcomes among SNF residents. We certainly look forward to hearing how DCHS will incorporate feedback from CLTCOA and others into the proposed system at your 3rd Stakeholder Meeting on December 12, 2022, which our staff, Board, and members plan to attend.

Please don't hesitate to call or email me if you have any further questions or concerns. You can reach me directly at 408-569-7778 or Jason@CLTCOA.org.

All of us at CLTCOA thank you again for your consideration. It's greatly appreciated.

Best regards,



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