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To: Department of Public Health Center for Health Care Quality
via CHCQRegulatiaons@cdph.ca.gov
From: Lydia Missaelides, Interim Executive Director
Date: November 8, 2023

Re: Comments regarding Proposed Updates to Licensing Fee Schedule

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Overall Comments as to Policy Implications and Structure

While we are disappointed that this proposal was developed without any discussion with us at the front end, we appreciate the opportunity to provide comments on the draft licensing fee change proposal.

The way fees are calculated is opaque and not related to the service the providers receive. We don't know if our small Adult Day Health Care (ADHC) community is subsidizing larger, better funded facilities. That is because we do not see the value being provided by licensing is proportional to the service that centers receive.

Therefore, we must take this opportunity to critique the overall policy of making the government function of licensing publicly funded facilities for the public's health and safety funded by the very facilities that are being regulated. There is a perverse incentive built into this policy to reward inefficiency on the part of the state because regardless of the cost of government's functions, their costs will be borne by the licensee. Whereas, the licensee does not have the luxury of passing on their increased costs of licensing and compliance to their government payors.

In the case of ADHC, unlike other licensees, the centers are completely reliant on public sources of reimbursement and cannot pass increased licensing costs on to other better reimbursing payors. While $10,800 may not seem like a cost burden compared to a hospital or clinic operation, for these small centers it is a significant cost. And, fees go up like clockwork every year, even though the perceived value the licensee receives in return from the state regulator is not apparent, nor has it improved year over year.

Furthermore, inefficiency is rewarded because surveyors in the licensing system are unfamiliar with ADHC regulations yet the cost of the time and resources required to learn and correctly apply ADHC regulations is baked into next year's licensing fee. There is no incentive for efficiency.

The provider is bearing the cost of learning the ADHC regulations and how they have been interpreted over the past 40 years. In addition, the inexperience of surveyors creates more work (and therefore costs) for all when rules are misapplied, paperwork is "lost" and records are not updated even after repeated attempts on the part of the provider. Unfortunately, the impulse of providers is to give in to licensing demands for corrections, even if the basis for the correction is wrong because of the fundamental imbalance of power and fear of losing a license.

Structural comments

Comment: The change from having a Northern and Southern Field Office responsible for ADHC surveys to a decentralized structure has consequences that must be addressed if there is an expectation that all parties perform efficiently and effectively. The expertise that was built over decades within the Orange County and San Jose Field Offices has not been disseminated as the structure for ADHC became decentralized. Providers should not have to pay for a learning curve each time a new surveyor is asked to work with an ADHC. The reason for this shift is understood. It saves travel time and expense.

However, decentralizing creates less consistency for ADHC across the state and impacts access to participants' care when surveys cause delays in a center being able to open and serve participants. We are observing a lack of consistency since the change to local Field Office involvement occurred.

Recommendation: Anyone who performs surveys at the local field office must be specifically trained for ADHC. There should be someone at every field office designated as an ADHC knowledge specialist. There should be a "help desk" where the surveyors can consult with designated regulatory experts at CDA and Central Operations when there is a question about regulatory authority or interpretation. This would facilitate more consistency across the various field offices and efficiency.

Structural Comments specific to Los Angeles County Transition for ADHC

We are extremely concerned that having LA county take over licensing functions would allow it to impose LA County specific requirements on top of the state level regulations, creating more regulatory authority confusion, unnecessary costs, and further divergence of the ADHC model from county to county. We have had consistency and stability in how the ADHC regulations are interpreted over many decades. It has taken a lot of work. This change to outsourcing licensing to LA county for ADHC is unprecedented and, in our view, unnecessary.

Recommendation: <u>We oppose this change to outsource ADHC licensing to LA County.</u>
Consistent with the general comments above, we recommend that the state CDPH Field Office in Los Angeles continue to be responsible for the ADHC sector. This state field office can build up the expertise needed to survey these unique facilities as opposed to ADHCs being a tiny fraction of a huge bureaucratic county public health structure that does not interact with ADHC for any other reason other than infection control/outbreaks. The state field office in Los Angeles is perfectly positioned to focus on ADHC since other providers already fall under the county jurisdiction. We also oppose the added surcharge of 25% for the purpose of the survey work

being shifted to LA County. This cost on top of the already high licensing fees is unnecessary to achieve the goal of health and safety.

Comments Related to Proposed Fee Structure

Comments: The proposed fee structure creates more cost burden and does not address the fundamental inefficiencies that are built into the current licensing structure. In fact, it encourages inefficiency by making the provider pay for errors of omission or system inefficiencies such as "losing" paperwork repeatedly sent by the licensee; not recording change of names of key personnel or address changes and so on. For each of these errors the provider would be paying a new fee, with little recourse if they want to maintain their license. The state has all the power and the provider will likely find it more cost and time effective to pay the fee repeatedly than to risk not being licensed, even when the error is not theirs, but the state's.

Recommendation: We urge a policy be enacted to reduce licensing fees for ADHC by 80% when a center serves 80% or more Medi-Cal or other government supported individuals.

Recommendation: We also urge a moratorium on licensing fees for two years to allow for analysis of the unique place that ADHCs play in serving the Medi-Cal population.

Comment: We are not confident that separating out user fees that we call "nickel and dime" fees, as proposed, will reduce the annual base licensing fee. For the small amount of revenue that these new fees will generate from some providers, we have a hard time envisioning that the cost/benefit ratio will tip in favor of benefitting providers who do not experience the need to pay these new fees. Until such time as see hard evidence of overall licensing fees being reduced, we oppose this change.

Recommendation: If this or a similar proposal advance, we recommend that there be an explicit cap on cumulative fees within a given year that should never be higher than the overall base CHOW licensing fee, inclusive of CHOW.

Second, there should be a delay in implementation and NO fees like these assessed until the state database is cleaned up and made current through explicit data verification by the provider to ensure accurate information is recorded in the database and we are not paying for CDPH mistakes.

Recommendation: Due to the upheaval in the workforce that has hit our ADHC community hard, centers should not be charged for changes in personnel. The centers have little control over turnover when the competition for the same workers is fierce.

Recommendation: ADHC should have a separate standard for change in capacity in relation to other providers because there are no centers that operate 1-5 person facilities. ADHC is not residential. If there must be a separate fee for change in capacity the cut off should be what makes sense for ADHC. No center will be asking for a change in capacity for a few people. It is not financially logical. The standard could be related to the point at which a new bathroom is needed. The ADHC standard has been 15 people.

Recommendation: We recommend that CDPH model a "sliding fee scale" scenario for ADHC fees. At present a 60-capacity facility pays the same $10,800 fee as a center licensed to serve 300. Such a graduated fee should be based on average daily attendance (ADA), which is not the same as capacity because one must take into account participant health and safety to be able to move about in the space with wheelchairs, walkers, canes, as well as distancing in the era of covid. CDA obtains regular data on ADA.

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