Article 9. Quality Assurance Fee and Long Term Care Reimbursement Methodology.

(1) Adopt Section 52000 to read as follows:

Section 52000. Definitions.

The following definitions shall apply only to Chapter 3. Article 9.

(a) "Administrator Compensation" means the remuneration paid to a facility administrator regardless of the form in which it is paid. "Administrator Compensation" includes salary, wages, fringe benefits, allowances, bonuses, debt forgiveness, severance payments, payments for accumulated but unused leave and payments of amounts previously deferred. "Administrator Compensation" includes fees regardless of the label placed on them, for example, consultant fees or director's fees.

(b) "Administrative Costs" means 1) expenses including the facility's portion of home office costs related to the overall management and administration of the facility, including those of the medical director, general and patient accounting activities, communication systems, data processing activities, patient admissions, governing board activities, public relations, liability insurance deductibles, paid liability losses, theft insurance, auto insurance, property insurance, licenses and taxes (other than property and income taxes and facility license fee), 2) taxes related to liability insurance, 3) the production of indexes, abstracts, and statistics for facility management uses, 4) procuring supplies, equipment and service necessary to facility operations, and 5) interest incurred on borrowing other than interest incurred on mortgage notes,

capitalized lease obligations and other borrowing for the acquisition of land, buildings and equipment.

(c) “Assisted Living Services” means those services including, but not limited to, assistance with personal activities of daily living including dressing, feeding, toileting, bathing, grooming, mobility, and associated tasks, to help provide for and maintain physical and psychosocial comfort.

(d) “Audited Cost Report Data” means data contained in audit reports issued by the Department.

(e) “Benchmark” means the maximum allowable cost.

(f) “Business Practice” means the methods, procedures, processes, or rules employed or followed by a facility in the pursuit of its objectives.

(g) “Capital Costs” means costs of depreciation and amortization expense on land improvements, building improvements, leasehold improvements and equipment; all leases and rental expenses related to building, equipment and leasehold improvements; and interest incurred on mortgage notes, capitalized lease obligations and other borrowing for the acquisition of land, buildings and equipment.

(h) “Captive Insurance Policies” means policies issued by insurance companies, established with the specific objective of financing risks emanating from a related entity or group. The operating entity insures all or part of its risks with its captive company. The captive company may reinsure some or all of such risks, or may retain such risks.

(i) “Certificate of Authority” means a certificate issued by the California Department of Social Services, properly executed and bearing the State Seal, authorizing a specified facility to enter into one or more continuing care contracts at a

single specified continuing care retirement community.

(j) “Corporate Structure” means the layout of the various departments, divisions, and job positions that interact to conduct the business of the facility.

(k) “Current Facility Value” means the greater of the estimated building and equipment value or the under-depreciated building and equipment value or the fully depreciated building and equipment value.

(l) “De-Certified” means not currently certified to participate in the Medi-Cal Program.

(m) “Direct Care Agency Costs” means expenditures for contractor staff for routine services and any ancillary services included in the Medi-Cal rate including all nursing, social services and activities.

(n) “Direct Care Labor Costs” means salary, wages and benefits for routine nursing services and any ancillary services included in the Medi-Cal rate including all nursing, social services and activities provided by employees of the facility, as well as direct care salary costs of services provided to the facility by a related entity.

(o) “Direct and Indirect Care Non-labor Costs” means costs related to services supporting the delivery of resident care (including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, medical records, in-service education and plant operations and maintenance costs), and expenses for contracted plumbers, gardeners, equipment service contracts, contracts for facility repairs or remodeling, security guards, alarm services, pickup and delivery laundry services, non-administrative consultants or any other service agreement and minor equipment.

(p) “Direct Pass-Through Costs for Care Giver Training” means costs, for a

formal program of education that is organized to train students to enter a care giver licensed or certified occupational specialty, which includes salaries, wages and benefits of the instructor and expenses for related training materials or supplies; or the cost of a contracted instructor if services are performed within the facility.

(q) “Direct Pass-Through Costs for Facility License Fees” means the annual fee for a license to operate a skilled nursing facility.

(r) “Direct Pass-Through Costs for Liability Insurance” means the reasonable cost of insurance premiums purchased from a commercial insurance carrier including the related brokerage fees or reasonable self insurance costs or reasonable costs of insurance purchased from a captive insurance company.

(s) “Fair Rental Value System (FRVS)” means a system where reimbursement to a facility is based on the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, rent or lease payments.

(t) “Freestanding Nursing Facility, Level-B (FS/NF-B)” means a licensed and certified skilled nursing facility that is not part of an acute care hospital and that meets the standards of participation in Welfare and Institutions Code Section 14091.21 and Title 22, California Code of Regulations Sections 51121 and 51215.

(u) “Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B)” means a licensed and certified skilled nursing facility as defined in subsection (t) and meets additional standards of participation to provide adult subacute care services, pursuant to Title 22, California Code of Regulations Section 51215.5.

(v) “Independent Living Services” means services provided to maximize the independence of individuals with disabilities and the accessibility of the communities in

which they live.

(w) “Indirect Care Agency Costs” means expenditures for contractor staff for housekeeping, laundry and linen, dietary, medical records, in service education, and plant operations and maintenance.

(x)”Indirect Care Labor Costs” means salary, wages and benefits for housekeeping, laundry and linen, dietary, medical records, in service education, and plant operations and maintenance for employees of the facility, as well as indirect care salary costs of services provided to the facility by a related entity.

(y) “In-service Education” means a program of instruction, or training, provided by a facility for its employees.

(z) “Labor Inflation Index” means a normalized average of labor inflation costs.

(aa) “Minor Equipment” means equipment or the combined equipment items of an integrated system with a useful life of less than 2 years and a cost of less than $5,000.

(bb) “Multi-Level Retirement Community (MLRC)” means a provider of a continuum of services, including independent living services, assisted living services and skilled nursing care on a single campus which has not received a certificate of authority or a letter of exemption from the Department of Social Services.

(cc) “Peer Group” means a group of counties that are categorized and clustered together by means of the following factors: geographic urban/rural status, median/average direct care per diem costs, and the frequency of provider facilities within each county.

(dd) “Rate Year” means the fiscal period from August 1 through July 31.

(ee) “Rental Factor” means the average 20-year US Treasury Bond yield for the calendar year preceding the rate year plus a two percent risk premium, subject to a floor of seven percent and a ceiling of ten percent.

(ff) “Replacement Project” means an asset that fills the place, position or purpose once filled by an asset that has been lost, destroyed, discarded or is no longer usable or adequate.

(gg) “Residential Care Facility for the Elderly” means a housing arrangement chosen voluntarily by persons 60 years of age or over, or their authorized representative, where varying levels and intensities of care and supervision, protective supervision, or personal care are provided, based upon their varying needs, as determined in order to be admitted and to remain in the facility. Persons under sixty years of age with compatible needs may be allowed to be admitted or retained in a residential care facility for the elderly as specified in Health and Safety Code Section 1569.316.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(2) Adopt Section 52100 to read as follows:

Section 52100. Quality Assurance Fee.

(a) Each rate year, Freestanding Nursing Facility, Level-Bs (FS/NF-Bs) and Freestanding Subacute Nursing Facility, Level-Bs (FSSA/NF-Bs) shall pay a uniform Quality Assurance Fee (QAF) pursuant to Health and Safety Code Section 1324.21, as described in Sections 52100 through 52104. The QAF shall not exceed the percentage set forth in Title 42, United States Code Section 1396b(w)(4)(C)(ii).

(b) Each FS/NF-B and FSSA/NF-B shall determine the amount due, as specified in Health and Safety Code Section 1324.21(b), by multiplying the QAF by the total resident days for the preceding quarter.

NOTE: Authority cited: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14105 and 14110.6, Welfare and Institutions Code.

(3) Adopt Section 52101 to read as follows:

Section 52101. Payment of the Quality Assurance Fee.

(a) Each FS/NF-B and FSSA/NF-B shall remit payment of the amount due to the Department on a monthly basis on or before the last day of the month following the month in which the QAF is imposed, with a completed Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee Payment Invoice form DHCS 9116 (Rev. 03 -10), herein incorporated by reference in its entirety.

(b) If a FS/NF-B or FSSA/NF-B fails to pay all or part of the amount due within 60 calendar days of the date the payment is due, as specified in subsection (a), the Department shall issue a delinquency notice to the FS/NF-B or FSSA/NF-B demanding payment within 15 calendar days of the date of the delinquency notice.

(c) Each FS/NF-B and FSSA/NF-B shall be liable for payment of interest at the rate of seven percent per annum on any unpaid amount due, beginning on the 61st calendar day from the date the payment is due, until the unpaid amount due, plus any interest, is paid in full.

(d) If a FS/NF-B or FSSA/NF-B fails to pay all or part of the outstanding amount due, the Department shall recover the unpaid amount due, plus interest, by one or more of the following methods, until paid in full:

(1) Offset any Medi-Cal reimbursement payments due to the FS/NF-B or FSSA/NF-B;

(2) Execute a repayment agreement between the FS/NF-B or FSSA/NF-B and the Department;

(3) Assess a penalty equal to 50 percent of the unpaid amount due;

(4) Recommend to the California Department of Public Health that license renewal be delayed until the Department has recovered the full amount due.

(e) After July 31, 2011, FS/NF-Bs and FSSA/NF-Bs shall remain liable for payment of any QAFs assessed prior to July 31, 2011, but not yet collected prior to that date, until the amount due, plus interest and penalties, is paid in full.

NOTE: Authority cited: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14105 and 14110.6, Welfare and Institutions Code.

(4) Adopt Section 52102 to read as follows:

Section 52102. Exemption from the Quality Assurance Fee.

(a) Facilities specified in Health and Safety Code Section 1324.20(b), are exempt from payment of the QAF, as specified in Section 52101.

(b) A “Multi-Level Retirement Community” (MLRC), as defined in Section 52000(bb) may request an exemption from the QAF, in accordance with Section 52103.

(c) An MLRC that has a change in corporate structure or business practice shall report this change to the Department by the last day of February. If a facility is no longer an MLRC, the facility will no longer be exempt from the QAF.

NOTE: Authority cited: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14105 and 14110.6, Welfare and Institutions Code.

(5) Adopt Section 52103 to read as follows:

Section 52103. Request for Exemption from the Quality Assurance Fee.

(a) A facility that meets the definition of an MLRC under Section 52000(bb), may request an exemption from the QAF once each rate year by submitting an application to the Department by the last day of February, for the subsequent rate year, which shall consist of all of the following information:

(1) A copy of the FS/NF-B or FSSA/NF-B license and Residential Care Facility For the Elderly (RCFE) license.

(2) The facility owner's name, federal tax identification number, and National Provider Identifier and the Office of Statewide Health Planning and Development number.

(3) Documentation that specifies that both the FS/NF-B or FSSA/NF-B and the RCFE are owned by the same entity.

(4) A description of the campus that demonstrates that a continuum of services, including independent living services, assisted living services and skilled nursing services are provided on a single campus.

(5) Documentation proving that the facilities are located on the same campus and are under the same ownership, if the addresses of the FS/NF-B or FSSA/NF-B and the RCFE are different.

(6) A statement under penalty of perjury that the facility has not received a certificate of authority or a letter of exemption from the Department of Social Services as specified in Health and Safety Code Section 1771.3.

(7) The total number of unlicensed Independent Living (IL) units and the total number of licensed Assisted Living (AL) Units.

(A) If a facility designates all of its IL and AL units under the RCFE license the facility shall provide documentation:

1. That the IL units and AL units are separately identifiable.

2. There is a provision in the agreement between the resident and the facility, which specifies when the level of care changes and how a transfer occurs from one facility type to a higher or lower level of care.

(B) A facility shall provide documentation that the total number of the IL and AL units is 60 percent or more and the FS/NF-B or FSSA/NF-B units is 40 percent or less of the total capacity of the campus.

(b) A facility shall apply for a QAF exemption on an annual basis in accordance with this section.

(c) A QAF exemption application shall be approved or denied by the Department within 60 calendar days from the receipt of the application.

NOTE: Authority cited: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14105 and 14110.6, Welfare and Institutions Code.

(6) Adopt Section 52104 to read as follows:

Section 52104. Quality Assurance Fee and Change of Ownership.

The amount due shall be assessed on each FS/NF-B and FSSA/NF-B irrespective of any change in ownership, change in ownership interest or control, or the transfer of any portion of the assets of a FS/NF-B and FSSA/NF-B to another owner. A new owner shall assume any and all liability for payment of the amount due, plus interest, owed by the facility.

NOTE: Authority cited: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14105 and 14110.6, Welfare and Institutions Code.

(7) Adopt Section 52500 to read as follows:

Section 52500. Facilities Subject to Facility-Specific Rate Setting System.

(a) Facilities subject to the reimbursement methodology, as described in Sections 52500 through 52516, and as authorized by Welfare and Institutions Code Section 14126 shall be Freestanding Nursing Facility, Level-Bs (FS/NF-B), and Freestanding Subacute Nursing Facility, Level-Bs (FSSA/NF-B).

(b) The per diem rate shall be calculated prospectively on a facility-specific basis using facility-specific cost report data as specified in Health and Safety Code Section 128730 with a fiscal period end date two years prior to the rate year.

(1) Cost report data shall be submitted in accordance with Title 22, California Code of Regulations Section 97040.

(2) Audited cost report data shall be used for facility-specific rate setting.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(8) Adopt Section 52501 to read as follows:

Section 52501. Facility Specific Rate Methodology.

The facility-specific cost-based per diem payment shall be based on the sum of the projected costs of the five major cost categories listed below and as specified in Welfare and Institutions Code Section 14126.023. Costs within a specific cost category shall not be shifted to any other cost category. The five major cost categories are as follows:

(a) Labor costs

(b) Direct and Indirect care non-labor costs

(c) Administrative costs

(d) Capital costs

(e) Direct pass-through costs

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(9) Adopt Section 52502 to read as follows:

Section 52502. Labor Costs Category.

(a) Labor costs shall be calculated by combining direct care labor costs, direct care agency costs, indirect care labor costs, indirect care agency costs, and labor driven operating allocation (LDOA).

(b) The Department shall calculate the daily direct care labor costs by combining direct care labor costs and direct care agency costs and dividing by total resident days.

(1) The benchmark for each daily direct care labor cost payment shall be the 90th percentile of each peer group.

(2) The Department shall reimburse each facility either at actual cost or the benchmark for its peer group, whichever is lower.

(3) The Department shall establish a labor inflation index using the most recent industry-specific historical wage data as reported to the Office of Statewide Health Planning and Development (OSHPD).

(4) Each facility's direct care labor costs shall be adjusted by the labor inflation index from the mid-point of the cost reporting period to the mid-point of the rate year.

(5) If a FSSA/NF-B enters into service agreements with unrelated contractors to operate physical therapy, speech pathology, occupational therapy, or respiratory therapy services, the contractor's documented cost of labor to work within the facility shall be included as direct care agency costs. If the facility does not submit to the Department the unrelated contractor's supporting documentation of the contractor's labor costs, all of the purchased service costs shall be included in other non-labor. If

the consultant is employed by a related entity, the cost is treated as if it was incurred by the facility.

(c) The Department shall calculate the daily indirect care labor costs by combining indirect care labor costs and indirect care agency costs and dividing by total resident days.

(1) If a facility employs a contractor to provide regularly scheduled daily staff needed to operate a facility department (such as plant operations, housekeeping, laundry and linen, or dietary), the contractor's documented labor costs shall be included in the indirect care agency costs. Facilities shall provide the Department with the portion of the contract agreement and other documents that identify the labor costs. If the facility fails to document the portion of the contract cost related to labor, the Department shall determine the indirect labor costs related to the contractor based on the following percentages:

(A) Plant Operations and Maintenance - 31 percent

(B) Housekeeping – 85 percent

(C) Laundry and Linen – 78 percent

(D) Dietary – 58 percent

(2) The benchmark for each daily indirect care labor cost payment shall be the 90th percentile of each peer group.

(3) The Department shall reimburse each facility either at actual cost or the benchmark for its peer group, whichever is lower.

(4) The Department shall establish a labor inflation index using the most recent industry-specific historical wage data as reported to OSHPD.

(5) Each facility's indirect care labor costs shall be adjusted by the labor inflation index from the mid-point of the cost reporting period to the mid-point of the rate year.

(d) The Department shall calculate the LDOA by combining the direct and indirect labor costs, subtracting the expenditures for direct care agency costs as well as the expenditures for the indirect care agency costs and multiplying the sum by 8 percent. The daily LDOA shall be calculated by dividing LDOA by the total resident days. The LDOA shall not exceed 5 percent of the facility's total Medi-Cal reimbursement rate.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(10) Adopt Section 52503 to read as follows:

Section 52503. Direct and Indirect Non-Labor Costs Category.

The Department shall calculate the daily direct and indirect non-labor costs by dividing direct and indirect non-labor costs by total resident days.

(a) The benchmark for each daily direct and indirect non-labor cost payment shall be the 75th percentile of each peer group.

(b) The Department shall reimburse each facility either at actual cost or the benchmark for its peer group, whichever is lower.

(c) Each facility's direct and indirect non-labor costs shall be adjusted by the California Consumer Price Index for All-Urban Consumers from the mid-point of the cost reporting period to the mid-point of the rate year.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(11) Adopt Section 52504 to read as follows:

Section 52504. Administrative Costs Category.

The Department shall calculate the daily administrative costs by dividing administrative costs by total resident days.

(a) The benchmark for each daily administrative cost payment shall be the 50th percentile of each peer group.

(b) The Department shall reimburse each facility either at actual cost or the benchmark for its peer group, whichever is lower.

(c) Each facility's administrative costs shall be adjusted by the California Consumer Price Index for All-Urban Consumers from the mid-point of the cost reporting period to the mid-point of the rate year.

(d) Administrator compensation for services, provided by sole proprietors, partners, officers, directors or other administrators of skilled nursing facilities defined in Health and Safety Code Section 1250(c), shall be limited to:

(1) The reasonable value of the services performed regardless of the type of service.

(2) Compensation essential to employ a staff person, in place of the administrator, in order to maintain the daily operations of the facility administrator.

(3) The value of comparable services provided at a similar facility, based on the size and classification of the facility, geographic location, the number and type of personnel supervised, the qualifications of the administrator and duties performed.

(4) The value of services rendered in connection with resident care as determined by arm's length transactions.

(e) If an assistant administrator is employed to perform duties of the administrator, this position shall be taken into consideration when determining reasonableness.

(f) To be considered “full-time” and receive compensation for providing full-time services, an administrator shall devote at least 40 hours per week to the services for which compensation is provided. An administrator who devotes less than 40 hours per week to the services for which compensation is provided shall be compensated an amount proportionate to a full-time basis.

(g) If an administrator performs services for several facilities, spending less than full-time at each facility, then the allowable compensation shall reflect an amount proportionate to a full-time basis.

(h) For purposes of determining reasonable compensation, the Department shall conduct surveys to collect data regarding facility administrators in both proprietary and non-proprietary facilities in like geographic locations.

(1) The data collected in the surveys from non-owner administrators, shall be used to develop compensation ranges by geographic location and number of beds to evaluate administrator compensation during audits and to adjust costs.

(2) The compensation ranges shall be based on data that reflects “full time” compensation and excludes extreme values and other data anomalies.

(3) For years when no survey is completed, the compensation ranges shall be updated by an inflation factor provided by the federal Centers for Medicare & Medicaid Services.

(i) Compensation paid to a relative of the owner of the facility shall be limited to the factors described in subsection (a). Relatives include:

(1) spouse;

(2) natural parent, child or sibling;

(3) adoptive parent or adopted child;

(4) stepparent, stepchild, stepbrother or stepsister;

(5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law;

(6) grandparent or grandchild.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(12) Adopt Section 52505 to read as follows:

Section 52505. Capital Costs Category.

(a) The Fair Rental Value System (FRVS) shall be used to reimburse facilities' capital costs. The FRVS methodology establishes a facility's value based on: the age of the facility, costs incurred and the fair rental value per diem calculation.

(1) The Department shall determine the age of each facility by calculating the difference between the midpoint of the current rate year, and one of the following values: a facility's original license date, the year of construction, some form of initial loan documentation or similar documentation.

(2) The Department shall determine the costs incurred for capital improvements, modifications, replacement projects or renovations equal to or greater than $500 per bed on a total licensed-bed basis by converting the costs incurred into an equivalent number of new beds. If a facility adds or replaces beds, these new beds shall be averaged in with the age of the original beds, and the weighted average age of all beds shall represent the facility's age.

(3) The Department shall determine the fair rental value per diem in the following manner:

(A) The estimated building value shall be calculated based on a standard facility size of 400 square feet per licensed bed and the R.S. Means Building Construction Cost Data adjusted for the facility location within California. The estimated building value shall be trended forward annually to the mid-point of the rate year using the percentage change in the R.S. Means Building Construction Cost index.

(B) The estimated equipment value shall be calculated by multiplying the number of facility beds by $4,000.

(C)1. The fully depreciated building and equipment value shall be calculated based on a 1.8 percent annual depreciation rate of 34 years, if the facility's age is at or over 34 years.

(C)2. The under-depreciated building and equipment value shall be calculated based on a 1.8 percent annual depreciation rate of the facility's age, if the facility's age is under 34 years.

(C)3. The value determined in subparagraph (C)1. or (C)2. shall be used in subparagraphs (D) through (F) below as the current facility value.

(D) An estimate of land value shall be added to the current facility value based on 10 percent of the estimated building value.

(E) The facility's total return value shall be calculated by multiplying the current facility value plus estimated land value, times the rental factor.

(F) The facility's total return value shall then be divided by the greater of actual resident days for the cost reporting period, or occupancy adjusted resident days, based on the statewide average occupancy rate. Days from partial year cost reports shall be annualized in the per diem calculation.

(b) Capital costs calculated under this section shall be limited to the maximum annual increase for the capital cost category for all facilities in the aggregate and shall not exceed 8 percent of the prior rate year's FRVS aggregate payment.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(13) Adopt Section 52506 to read as follows:

Section 52506. Direct Pass-Through Costs Category.

(a)(1) Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, the Medi-Cal portion of the facility quality assurance fee, and new state and federal mandates for the applicable rate year.

(2) The Medi-Cal proportional share of the pass-through per diem costs shall be calculated as the facility actual allowable Medi-Cal cost as reported on the facility's most recent available cost report, as adjusted for audit findings.

(b) The Department shall calculate the daily costs of the property tax pass through by dividing property tax costs by total resident days.

(1) The Department shall update the property tax pass-through costs at the rate of 2 percent annually.

(2) Each facility's property tax costs shall be increased from the mid-point of the cost reporting period to the mid-point of the rate year.

(c) The Department shall calculate the daily direct pass-through costs for facility license fees by multiplying the current annual fee by the number of licensed facility beds and then dividing that product by total resident days.

(d) The Department shall calculate the daily direct pass through costs for care giver training by dividing care giver training costs by total resident days.

(1) The Department shall apply the California Consumer Price Index for All-Urban Consumers to allowable care giver training costs.

(2) Each facility's care giver training costs shall be increased from the mid-point of the cost reporting period to the mid-point of the rate year.

(e) The Department shall calculate the daily direct pass through costs for liability insurance by dividing liability insurance costs by total resident days.

(1) The Department shall apply the California Consumer Price Index for All-Urban Consumers to allowable liability insurance cost.

(2) Each facility's liability insurance costs shall be increased from the mid-point of the cost reporting period to the mid-point of the rate year.

(3) Facilities that use Self insurance or have Captive Insurance Policies for professional liability insurance coverage shall comply with and be subject to the following provisions:

(A) The facility shall maintain an insurance reserve fund to meet any actual losses sustained. In the event of a loss, the amount allowable shall be limited to the balance in the reserve fund at the date of the loss.

(B) The facility shall provide to the Department documentation about the specific assets that are to be covered by the insurance reserve fund.

(C) The insurance reserve fund shall be maintained in a segregated account and the funds shall not be commingled with any other funds.

(D) The insurance reserve fund shall be sufficient to meet losses of the type and to the extent that they would ordinarily be covered by insurance.

(E) Contributions to the insurance reserve fund shall be made not less frequently than annually.

(F) The facility's total allowable interest expense under the Medi-Cal program shall be offset by income earned by invested insurance reserve funds.

(G) Any income earned by the insurance reserve fund shall become part of the insurance reserve fund and used in establishing adequate insurance reserve fund levels.

(H) Where appropriate, the facility shall demonstrate the ability to effectively replace the inspection service, the loss-handling service, and the legal defense service of the insurance companies.

(I) The treatment of casualty losses sustained by the insurance reserve fund shall be limited to the balance of the insurance reserve fund at the date of loss.

(J) The Department shall determine the reasonable cost of self insurance or insurance purchased from a related captive insurance company based on the FSSA/NF-B cost reports filed with the Department. Insurance costs determined to be unreasonable shall be excluded from the FSSA/NF-B cost reports during the cost report audit process specified in Welfare and Institutions Code Section 14170.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(14) Adopt Section 52508 to read as follows:

Section 52508. Peer-Groups.

(a) The Department shall place FS/NF-Bs in each county in the following peer groups:

Peer Group Number	**County**
1	Colusa
	Del Norte
	Imperial
	Kern
	Kings
	Lake
	Lassen
	Tulare
	Yuba
2	Butte
	Humboldt
	Inyo
	Madera
	Mendocino
	Merced
	San Luis Obispo
	Tehama

Peer Group Number	County
	Yolo
3	Calaveras
	Glenn
	Plumas
	San Joaquin
	Shasta
	Siskiyou
	Stanislaus
	Sutter
	Ventura
4	Amador
	El Dorado
	Nevada
	Placer
	Tuolumne
5	Los Angeles
6	Fresno
	Orange
	Riverside
	San Bernardino
	San Diego
	Santa Cruz

Peer Group Number	County
	Solano
7	Alameda
	Contra Costa
	Marin
	Monterey
	Napa
	Sacramento
	San Francisco
	San Mateo
	Santa Barbara
	Santa Clara
	Sonoma

(b) FSSA/NF-Bs shall be in their own peer group.

(c) The seven counties in California that have no Medi-Cal skilled nursing days shall be excluded from the peer groups identified in subsection (a).

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(15) Adopt Section 52509 to read as follows:

Section 52509. Rate-Setting for State-Owned Facilities (FS/NF-Bs).

State-owned and operated FS/NF-Bs shall receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(16) Adopt Section 52510 to read as follows:

Section 52510. Rate-Setting for Newly Certified Facilities.

(a) Facilities newly certified to participate in the Medi-Cal program, shall receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. Facilities shall continue to receive the peer-group weighted average Medi-Cal reimbursement rate until one of the conditions of subsection (b)(1) or (b)(2) has been met.

(b)(1) The Department shall calculate the FS/NF-B facility-specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Welfare and Institutions Code Section 14126.021.

(b)(2) The Department shall calculate the FSSA/NF-B facility-specific rate when a cost report with a minimum of twelve months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Welfare and Institutions Code Section 14126.021.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(17) Adopt Section 52511 to read as follows:

Section 52511 Rate-Setting for De-Certified Facilities

(a) Facilities that have been de-certified for less than six months and upon recertification shall continue to receive the facility per diem reimbursement rate in effect prior to decertification. Facilities shall continue to receive the facility per diem reimbursement rate until one of the conditions in paragraph (1) or (2) have been met.

(1) The Department shall calculate the FS/NF-B facility-specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate based on the audited six months of Medi-Cal cost data shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Welfare and Institutions Code Section 14126.021.

(2) The Department shall calculate the FSSA/NF-Bs facility-specific rate when a cost report with a minimum of twelve months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Welfare and Institutions Code Section 14126.021.

(b) Facilities that have been de-certified for six months or longer and upon recertification shall receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. Facilities shall continue to receive the peer-group weighted average Medi-Cal reimbursement rate until one of the conditions in paragraph (1) or (2) have been met.

(1) The Department shall calculate the FS/NF-B facility-specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate

shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Welfare and Institutions Code Section 14126.021.

(2) The Department shall calculate the FSSA/NF-Bs facility-specific rate when a cost report with a minimum of twelve months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Welfare and Institutions Code Section 14126.021.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(18) Adopt Section 52512 to read as follows:

Section 52512. Rate-Setting for Facilities with Changes of Ownership.

(a) Facilities that have a change of ownership or changes of the licensed operator shall continue to receive the facility per diem reimbursement rate in effect with the previous owner. Facilities shall continue to receive the facility per diem reimbursement rate until one of the conditions in subsection (b)(1) or (b)(2) have been met.

(b)(1) The Department shall calculate the FS/NF-B facility-specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Welfare and Institutions Code Section 14126.021.

(b)(2) The Department shall calculate the FSSA/NF-Bs facility-specific rate when a cost report with a minimum of twelve months of Medi-Cal cost data has been audited The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Welfare and Institutions Code Section 14126.021.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(19) Adopt Section 52513 to read as follows:

Section 52513. Change in Facility Fiscal Period.

Except for changes in ownership, when a facility files more than two Office of Statewide Health Planning and Development reports in a calendar year, the Department shall use the most recent facility fiscal period available.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(20) Adopt Section 52514 to read as follows:

Section 52514. Out-of-State Providers.

Reimbursement for out-of-state providers shall be the statewide facility-specific weighted average rate applicable to the rate year during which services are provided.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(21) Adopt Section 52515 to read as follows:

Section 52515. Hospice.

Reimbursement for hospice room and board services under the facility-specific rate methodology shall be 95 percent of the rate applicable to the facility in which the resident resides.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(22) Adopt Section 52516 to read as follows:

Section 52516. Audits and Audit Adjustments.

(a) The Department shall conduct financial audits of FS/NF-Bs participating in the Medi-Cal program a minimum of once every three years. These audits may be full-scope field audits or limited scope reviews. Limited scope reviews shall be conducted at intervening periods. All FSSA/NF-Bs shall be subject to audit or review on an annual basis.

(b) Audited or reviewed cost data shall be used to develop facility-specific reimbursement rates.

(c) Overpayments to any facility shall be recovered pursuant to Welfare and Institutions Code, Section 14126.023 and Title 22, California Code of Regulations, Section 51047.

(d) Facilities have the right to appeal audit or examination findings that result in an adjustment to Medi-Cal reimbursement rates. Specific appeal procedures are contained in Welfare and Institutions Code Section 14171, and Title 22, California Code of Regulations, Sections 51016 through 51048.

(e) For facilities that obtain an audit appeal decision that results in revision of the facility's allowable costs used to calculate a facility's reimbursement rate, the Department shall make a retroactive adjustment in the facility-specific reimbursement rate.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.

(23) Adopt Section 52600 to read as follows:

Section 52600. Provider Bulletin Authority.

For purposes of rate years occurring prior to August 1, 2010, the Department may continue to apply those standards and other regulatory provisions and guidance issued in provider bulletins applicable to those rate years notwithstanding any changes in the prospective application of such bulletin provisions.

NOTE: Authority: Sections 20 and 1324.20 through 1324.30, Health and Safety Code; and Sections 10725, 14105, 14124.5, and 14126 through 14126.035, Welfare and Institutions Code. Reference: Sections 14105, 14109.5, 14110.1, 14110.6, 14132, 14170, and 14171 Welfare and Institutions Code.