§ 14170.5. Special claims review period

(a) No provider's claims for reimbursement under this chapter shall be subject to any special claims review procedure for a period in excess of nine months unless the department shows cause why the provider's claims for reimbursement should continue to be subject to special claims review procedures.

(b) The department shall provide notice to a provider of its reasons for determining that the provider shall be subject to extended special claims review.

(Added by Stats.1987, c. 608, § 1.)

§ 14171. Findings of audit or examination; administrative appeal processes for tentative or final settlements; informal conferences; time limitations; final decision; interest

(a) The director shall establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination made pursuant to Sections 10722 and 14170.

(b) Different administrative appeal processes may be established by the director for grievances or complaints arising from the determinations of a tentative or final settlement based on audit or examination findings made by or on behalf of the department pursuant to Sections 10722 and 14170, except that consistent with existing practice, no administrative appeal shall be available for tentative settlement of cost reports.

(c) The administrative appeal process established by the director for final settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations shall include the procedural requirements of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The impartial hearing shall be conducted by an administrative law judge appointed by the director. The director may subcontract with the Office of Administrative Hearings to conduct hearings on cases involving complicated issues of fact or law, or to reduce the backlog of cases.

(d) The administrative appeal process established by the director for tentative settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations shall be an informal process which, however, guarantees a provider the right to present any grievance or complaint to the department in writing. Any subsequent hearings shall be conducted in an informal manner and shall be held at the discretion of the department.

(e) The time limitations in subdivisions (f) and (g) for the impartial hearing and the final decisions are mandatory. If the department fails to conduct the hearing or to adopt a final decision thereon within the time limitations provided in subdivisions (f) and (g), the amount of any overpayment which is

(f) The development of alternative standards for beneficiary eligibility and copayment under Medi-Cal.

(g) The development of a method of response to temporary deficits in the Medi-Cal program that will both control expenditures and, to the extent possible, preserve the availability to beneficiaries of essential health services.
(Added by Stats.1983, c. 960, § 7.)

Article 5.3

AUDIT, APPEAL, AND RECOVERY OF OVERPAYMENTS

Section

14170. Audits; controls; cost reports; corrections; payroll records; maintenance.
14170.1. Underpayments for pharmaceutical services; credit against overpayments.
14170.5. Special claims review period.
14171. Findings of audit or examination; administrative appeal processes for tentative or final settlements; informal conferences; time limitations; final decision; interest.
14171.5. Receipt of reimbursement to which county is not entitled; interest and penalties.
14172. Outstanding amounts resulting from overpayments; filing of certificate; entry of judgment.
14172.5. Statement of account status or demand for repayment; liquidation of overpayments to institutional providers; adjustment of payments to insure no overpayments.
14173. Abstract of judgment, recording; liens; executions; sales.
14174. Collection procedures; summary judgment.
14175. Liens; release.
14176. Overpayments; recovery; repayment agreements.
14177. Overpayments; recovery; offset against amounts due.
14178. Counties held harmless for acts performed before July 1, 1982; audit exception; applicability.

Article 5.3 was added by Stats.1977, c. 1046, p. 3172, § 6.

Operative effect

Chapter to remain operative during times federal aid available, see § 14020.

Code of Regulations References

Health care services, provider audit appeals, see 22 Cal. Code of Regs. 51016 et seq.

§ 14170. Audits; controls; cost reports; corrections; payroll records; maintenance

Amounts paid for services provided to Medi-Cal beneficiaries shall be audited by the department in the manner and form prescribed by the department. The department shall maintain adequate controls to ensure responsibility and accountability for the expenditure of federal and state funds. Cost reports and other data submitted by providers to a state agency for the purpose of determining reasonable costs for services or establishing

rates of payment shall be considered true and correct unless audited or reviewed by the department within 18 months after July 1, 1969, the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later. Moreover the cost reports and other data for cost reporting periods beginning on January 1, 1972, and thereafter shall be considered true and correct unless audited or reviewed within three years after the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later.

Nothing in this section shall be construed to limit the correction of cost reports or rates of payment when inaccuracies are determined to be the result of intent to defraud, or when a delay in the completion of an audit is the result of willful acts by the provider or inability to reach agreement on the terms of final settlement.

Notwithstanding any other provision of law, nursing facilities and all categories of intermediate care facilities for the developmentally disabled which have received and are receiving funds for salary increases pursuant to Sections 14110.6 and 14110.7 shall maintain payroll and personnel records for examination by auditors from the department and the Labor Commissioner beginning March 1985 until the records have been audited, or until December 31, 1992, whichever occurs first.

(Added by Stats.1977, c. 1046, p. 3172, § 6. Amended by Stats.1978, c. 429, § 248.1, eff. July 17, 1978, operative July 1, 1978; Stats.1981, c. 1129, p. 4408, § 1; Stats.1985, c. 787, § 1, eff. Sept. 19, 1985; Stats.1989, c. 731, § 23; Stats.1990, c. 1329 (S.B.1524), § 32, eff. Sept. 26, 1990.)

Historical and Statutory Notes

Section 2 of Stats.1978, c. 19, p. 80, amended by Stats.1981, c. 1129, p. 4410, § 2, and § 2.5 of Stats.1978, c. 19, added by Stats.1981, c. 1129, p. 4412, § 3, and amended by Stats.1985, c. 787, § 2, provide:

"Sec. 2. (a) The Legislature hereby finds and declares that a high rate of turnover among staff in intermediate care facilities and skilled nursing facilities diminishes the quality of care rendered to patients in those facilities. The Legislature further finds that the turnover among employees of those facilities is substantially attributable to the fact that the wages paid those employees are generally lower than the wages paid employees of other health care institutions in similar job classifications. It is the intent of the Legislature that Medi-Cal reimbursement rates for skilled nursing facilities and intermediate care facilities, to the extent feasible, be set at levels sufficient to allow those employees to be paid at wages which are sufficient to reduce turnover among such employees, in order to improve the level and quality of patient care.

"(b) The Legislature further finds that the rates for wages contained in this act were developed with recognition of the costs of increased wages and related benefits. It is the intent of the Legislature that the funds resulting from the Medi-Cal rate increases provided in this section be used for wage increases and for costs of normal benefit increases related to the wage and salary increases.

"(c) Notwithstanding any other provision of law, the State Director of Health Services shall establish and implement regulations effective March 1, 1978, that establish a payment rate for intermediate care facilities and skilled nursing facilities as defined in Section 1250 of the Health and Safety Code, which is sufficient to provide an increase of two dollars and twenty-eight cents ($2.28) per patient-day with respect to skilled nursing facilities and one dollar and eighty-four cents ($1.84) per patient-day with respect to intermediate care facilities, for wages and benefits of nonadministrative employees. The increase required by this section shall be in addition to any future mandatory increases required by federal or state law. The rate shall provide funding for the portion of additional costs necessary to implement the wage and benefit increase required by this

section attributable to Medi-Cal patients. The portion of those additional costs shall be the same as the ratio of Medi-Cal patients to the total patients in the facility.

"(d) Each skilled nursing facility or intermediate care facility shall certify that funds received pursuant to this section for the period commencing March 1, 1978, to and including June 30, 1978, are expended for employee wages and benefits, except if the entry level wages of the lowest paid nonadministrative employee of a skilled nursing facility or an intermediate care facility exceeds three dollars and ninety-seven cents ($3.97) per hour on the effective date of this section, the funds received pursuant to regulations adopted pursuant to this section shall be used to ensure the continued delivery of quality care in that facility. The base, from which employee wages and benefits are increased pursuant to this section, shall be the facility payroll for the month of December, 1977, but including only nonovertime hours worked by covered employees, plus any amount received pursuant to Section 1439.7 of the Health and Safety Code. For purposes of determining the amount of Medi-Cal funds to be distributed for employee wages and benefits, the total Medi-Cal patient-days recorded by the facility in the month of December, 1977, shall be multiplied by the amount per patient-day specified in subdivision (c) of this section.

"(e) The director shall inspect relevant payroll and personnel records of skilled nursing facilities and intermediate care facilities which are reimbursed for Medi-Cal patients under the rate of reimbursement established pursuant to subdivision (c) of this section to insure that the wage and benefit increases provided for have been implemented.

"(f) Any facility which is paid under the rate provided for in which the director finds has not made the wage and benefit increases provided for shall be liable to the employees for the amount of funds paid to the facility based upon the wage and benefit requirements provided for by this section but not distributed to employees for wages and benefits. The facility shall make payment of the outstanding amounts to the state for appropriate distribution, plus an amount equal to 10 percent of the funds not so distributed, to be retained by the state as a penalty.

"(g) On or before July 1, 1978, and annually thereafter, each skilled nursing facility or intermediate care facility shall certify to, and in the manner prescribed by, the director, all of the following:

"(1) All nonadministrative employees of the facility employed less than three months receive at least an entry level wage amounting to the prevailing federal minimum wage rate plus 50 percent of the average hourly wage increase established pursuant to this section for that facility during the period March through June, 1978.

"(2) All nonadministrative employees of the facility employed three months or more receive at least the prevailing federal minimum wage rate plus the average hourly wage increase established pursuant to this section for that facility during the period March through June, 1978; provided, however, that no employee then employed shall receive a wage less than that which that person received pursuant to this section for the period March through June, 1978, after July 1, 1978.

"(3) Any wage increase required pursuant to subdivision (a) of Section 1338 of the Health and Safety Code is in addition to any minimum wages provided in this subdivision.

"Sec. 2.5. (a) The Labor Commissioner is hereby authorized to audit payroll and personnel records of skilled nursing facilities and intermediate care facilities for the purposes of ensuring compliance with the wage levels provided for in this chapter.

"(b) The Labor Commissioner is hereby authorized to recover from the skilled nursing facility or the intermediate care facility any wages less than the minimum provided for in this chapter. The recovered funds shall be provided to the employees who were underpaid.

"(c) The Labor Commissioner may recover any funds not used for increases in wages pursuant to Sections 14110.6 and 14110.7 of the Welfare and Institutions Code. The recovered funds shall be provided to the employees who were underpaid. All penalties collected pursuant to these sections shall be forwarded to the Controller for deposit in the General Fund.

"(d) The Labor Commissioner is hereby authorized to impose any other penalties within his or her powers against any skilled nursing facility or intermediate care facility that is in violation of the wage requirements of this chapter. The amount of any penalties already paid to the State Department of Health Services pursuant to this chapter shall be deducted from the amount of any unpaid penalties imposed by the Labor Commissioner pursuant to this chapter. The amount of any penalties already paid to the Labor Commissioner pursuant to this chapter shall be deducted from the amount of any unpaid penalties imposed by the State Department of Health Services pursuant to this chapter.

Any evidence of failure to pay wage ... as provided for by this chapter shall be provided to the Labor Commissioner."

Amendment of this section by § 1.5 of Stats. 1981, c. 1129, p. 4409, failed to become operative under the provisions of § 4 of that Act.

Code of Regulations References

Requirements for electronic claims submission, see 22 Cal. Code of Regs. 51502.1.

Library References

Social Security and Public Welfare ⇐241.65.
WESTLAW Topic No. 356A.

C.J.S. Social Security and Public Welfare §§ 137, 138.

Notes of Decisions

Limitation of actions 1

1. Limitation of actions

Even if Medi-Cal services provider was entitled to avoid exhaustion of administrative remedies and proceeded directly to trial court on its appeal of 1972 audit adjustment, it did not do so within the applicable statute of limitations and its claim was barred for that reason. Pacific Coast Medical Enterprises v. Department of Benefit Payments (1983) 189 Cal.Rptr. 558, 140 C.A.3d 197.

§ 14170.1. Underpayments for pharmaceutical services; credit against overpayments

(a) Prior to the issuance to a provider of pharmaceutical services of any demand for payment pursuant to an audit or examination conducted under Sections 10722 and 14170, the amount of any underpayment to the provider for validly submitted claims or for valid claims which have inadvertently not been submitted and which arose during the audit period shall be determined and credited toward the amount of any overpayment due to the department. This section shall apply to all audits and examinations conducted under ...tions 10722 and 14170 relative to amounts paid during the audit period for services provided to Medi-Cal beneficiaries. No audit may be reopened to provide for underpayments in which a final decision has been reached pursuant to Section 14171 or in which a certificate has been filed pursuant to Section 14172.

(b) When a provider of pharmaceutical services asserts that a claim has been underpaid for purposes of receiving a credit against overpayments, as authorized by this section, the provider shall submit to the department information and documentation sufficient to resolve any dispute as to whether such claim was in fact underpaid.

(c) For purposes of this section, the term "underpayments" shall include errors made by the pharmacist and errors made by the fiscal intermediary in determining payments for claims submitted within the billing time limits specified in Section 14115.

(Added by Stats.1983, c. 1146, § 1. Amended by Stats.1986, c. 562, § 1.)

Library References

Social Security and Public Welfare ⇐241.110.
WESTLAW Topic No. 356A.

C.J.S. Social Security and Public Welfare § 136.

**TRANSITIONAL INPATIENT CARE (TC)
HFPA TRIGGERING**

FACILITY	*NO TC CONTRACTOR HFPA IS NOT TRIGGERED*	*TC CONTRACT AWARDED HFPA TRIGGERED TC BEDS UNAVAILABLE**	*TC CONTRACT AWARDED HFPA TRIGGERED TC BEDS AVAILABLE*
Hospital with TC contract	Not Applicable	[redacted]	[redacted] May transfer patient
Hospital without TC contract	Retain patient at Hospital Inpatient Services Reimbursement**	[redacted]	No TC Authorization****

*Transitional inpatient care beds may not be available because all the beds in the transitional inpatient care units are occupied, or facilities may not accept the patient due to level of care or staffing considerations.

**The hospital inpatient services reimbursement for contracted hospitals as provided in Article 2.7 of the Welfare and Institutions Code shall be the rate specified in the hospital contract. The hospital inpatient services reimbursement for non-contract hospitals is set forth in Article 7.5 of Title 22 California Code of Regulations. Reimbursement at this level will be made if the hospital is not in an area triggered as provided in subsection (b)(3).

***Acute administrative day process applies as specified in the Manual of Criteria for Medi-Cal authorization.

****Transitional inpatient care days will not be authorized in this circumstance.

(1) The hospital referral area for transitional inpatient care placement shall not impose additional commute from the general acute care hospital location of more than 15 miles, which shall be defined as 30 minutes at 30 miles per hour, for the person designated as the patient's primary visitor.

(2) The Department and general acute care hospitals shall maintain a list of all health facilities which have contracted to provide transitional inpatient care. General acute care hospitals shall receive written notification from the Department of changes to that list. Upon request, a list of current health facilities contracted to provide transitional inpatient care shall be available from the Department. The certified nursing facilities included on this list shall be contacted before any other certified nursing facility in placement attempts for any appropriate Medi-Cal patient.

(3) The Department will reimburse general acute care hospitals for transitional inpatient care services, provided in licensed acute care hospital beds, at the hospital inpatient services reimbursement rate until there is a contracted transitional inpatient care provider within the general acute care hospital's Health Facility Planning Area (HFPA) as developed by the Office of Statewide Health Planning and Development pursuant to Health and Safety Code Sections 127000 et seq. If a general acute care hospital is within 15 miles (which shall be defined as 30 minutes at 30 miles per hour) of a health facility in a neighboring HFPA that contracts to provide transitional inpatient care, the hospital will be considered within the contracted health facility's HFPA and subject to the provisions of transitional inpatient care reimbursement. The HFPA shall be triggered for transitional inpatient care when a provider is awarded a contract to provide transitional inpatient care. The HFPA shall be triggered for transitional rehabilitation care when a provider is awarded a contract to provide transitional rehabilitation care. The word "triggered" means that there is a contracted transitional inpatient care provider in the HFPA, and general acute care hospitals within that HFPA, or neighboring HFPA, as specified, will receive the transitional inpatient care reimbursement of [redacted] for the care rendered to qualified patients if:

(A) The general acute care hospital maintains a transitional inpatient care contract with the Department; or

(B) The general acute care hospital does not have a transitional inpatient care contract with the Department but makes daily attempts and documents daily attempts to place the qualified transitional inpatient care patient in a transitional inpatient care unit.

(4) For general acute care hospitals that contract for the provision of transitional inpatient care services provided in licensed general acute care hospital beds, the Department will reimburse the transitional inpatient care per diem of [redacted] when the general acute care hospital's HFPA is designated a trigger area.

(5) General acute care hospitals in that HFPA will be provided notice that the transitional inpatient care reimbursement rate will be paid to the general acute care hospital for a transitional inpatient care patient.

(c) In specified HFPAs, the reimbursement to health facilities for transitional medical care and transitional rehabilitation care provided to Medi-Cal patients shall be based on a negotiated contract. "Negotiated contract" means an executed contract resulting from negotiations, competitive bidding or any other method the Department deems appropriate as permitted by Sections 14087.3 and 14132.22(o) of the Welfare and Institutions Code.

(1) The contracting process used for a negotiated contract shall include, but not be limited to, the following steps:

(A) The Department will first determine the Medi-Cal patients' transitional inpatient care needs within the HFPA. Projections of transitional inpatient care service for patients within the HFPA will then be established. The projected transitional inpatient care service needs within the HFPA will be met by negotiating contracts for sufficient bed capacity.

(B) Health facilities as specified in Section 14132.22 of the Welfare and Institutions Code in an HFPA selected by the Department will be notified of the opportunity to negotiate a contract for the provision of transitional inpatient care services to Medi-Cal patients.

(C) Health facilities which indicate an interest in negotiating a contract for the provision of transitional inpatient care will be asked to present their proposal to the Department.

(D) The Department will contract with only the number of providers necessary to assure sufficient bed capacity and accessibility of transitional inpatient care services within the HFPA to Medi-Cal patients. Transitional inpatient care capacity projected to be needed in an HFPA may be contracted for in a neighboring HFPA.

(E) All affected health facilities in each HFPA will be notified when projected needs have been met in accordance with paragraphs (A) and (D). Affected hospitals will be designated as contracting for transitional inpatient care or non-contracting for transitional inpatient care and will be notified of facilities contracting to meet the projected transitional inpatient care needs within the HFPA.

(F) Once designation has occurred in accordance with paragraph (E), the Department is exempt from the provisions of paragraphs (B) and (C).

(2) Hospitals, without a negotiated contract for transitional inpatient care, shall receive the administrative day reimbursement of [redacted] for the provision of transitional inpatient care to Medi-Cal patients as long

as placement attempts to facilities with a transitional inpatient care contract are documented.

(d) Payment under subsection (a) and (b) shall only be made for services authorized pursuant to conditions set forth in Section 51335.1 for a patient determined to need transitional inpatient care services.

(e) Each provider of transitional inpatient care services shall furnish equipment, drugs, supplies, and services necessary to provide transitional level services except as provided in subsection (d). Such equipment, drugs, supplies, and services are, at a minimum, those which are required by law, including those required by federal Medicaid regulations and state licensing regulations.

(f) Not included in the per diem reimbursement and to be billed separately by the provider thereof, subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are:

(1) Allied health services, except occupational therapy, physical therapy, speech therapy and respiratory therapy

(2) Blood, plasma, and substitutes

(3) Dental services

(4) DME as specified in Section 51321(g), except suction pumps, IV poles, oxygen and oxygen therapy equipment, excluding ventilators

(5) Decubitus care equipment

(6) Traction equipment and accessories

(7) Hemodialysis

(8) Insulin

(9) Laboratory services

(10) Legend drugs

(11) MacLaren or Pogon Buggy

(12) Medical supplies as specified in Section 59998, except hypodermoclysis sets and intravenous solutions administration sets

(13) Osteogenesis stimulator device

(14) Physician services

(15) Plasmapheresis

(16) Prescribed prosthetic and orthotic devices for exclusive use of patient

(17) Reagent testing sets

(18) X-rays

(g) Not included in the transitional inpatient care per diem reimbursement rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shave or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental.

(h) Payment for leave of absence for the transitional rehabilitation patient authorized in accordance with Section 51335.1(p) shall be made pursuant to Section 51535.

(i) Payment for bedhold authorized in accordance with Section 51335.1(q) shall be made pursuant to Section 51535.1.

(j) Reimbursement to physicians for all medically necessary care provided to transitional inpatient care patients shall be commensurate with those visits to non-transitional acute care patients in general acute care hospitals.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 127000 et seq, Health and Safety Code; and Sections 14105.981 and 14132.22, Welfare and Institutions Code.

HISTORY

1. New section filed 4-1-96 as an emergency; operative 4-1-96 (Register 96, No. 14). A Certificate of Compliance must be transmitted to OAL by 9-30-96 pursuant to Welfare and Institutions Code section 14132.22 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of subsection (b), table, subsection (f), and HISTORY 1 (Register 96, No. 35).
3. New section refiled 9-28-96 as an emergency; operative 9-30-96 (Register 96, No. 35). A Certificate of Compliance must be transmitted to OAL by 1-28-97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9-28-96 order, including amendment of section, transmitted to OAL 1-22-97 and filed 3-10-97 (Register 97, No. 11).

§ 51511.5. Nursing Facility Services—Subacute Care Reimbursement.

(a) The all-inclusive per diem rates of reimbursement for subacute services as defined in Section 51335.5(a) shall be the lesser of the facility's costs as projected by the Department or the prospective class median rates of:

Type of Licensure	*Type of Patient*	*Rate of Reimbursement*
Hospital-based	Ventilator dependent	[redacted]
Freestanding	Ventilator dependent	[redacted]
Hospital-based	Nonventilator dependent	[redacted]
Freestanding	Nonventilator dependent	[redacted]

(b) Payments to nursing facilities with subacute care units for patients on bedhold receiving acute services shall be in accordance with section 51535.1(d).

(c) The provisions of section 51511 shall apply to subacute care units except for section 51511(a). Section 51511(c) shall apply to subacute providers with the exception of items included within the subacute rate pursuant to section 51511.5(d).

(d) Included within the subacute care per diem rate are all services, equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria including but not limited to:

(1) Oxygen and all equipment necessary for administration including positive pressure apparatus.

(2) Ventilators, including calibration and maintenance.

(3) Feeding pumps and equipment necessary for tube feedings, including formula.

(4) Speech therapy.

(5) Occupational therapy.

(6) Physical therapy.

(7) Equipment and supplies necessary for the care of a tracheostomy.

(8) Lab, X-ray and transportation services.

(9) Equipment and supplies for continuous IV therapy.

(10) Equipment and supplies necessary for debridement, packing and medicated irrigation with or without whirlpool treatment.

(e) For purposes of this section, the rate year is August 1, 1996 through July 31, 1997.

(f) The facility's projected cost shall be based on the audit report findings of cost reports with fiscal periods ending January 1, 1994 through December 31, 1994. In the event that a facility's audit report findings do not include subacute ancillary costs, the facility's projected ancillary cost will be based on the median of the subacute ancillary costs of facilities that had audited ancillary cost.

(g) If the audit of a cost report is not issued by July 1, 1996, the Department shall establish an interim projected reimbursement rate based on the cost report with a fiscal period ending January 1, 1994 through December 31, 1994, adjusted by an audit disallowance factor of .96414.

(h) The Department will use the facility's interim projected reimbursement rate in the computation of the prospective class median rate. In addition, facilities that did not provide subacute care services to Medi-Cal patients during the cost report period and/or facilities with less than a full year's reported cost shall not be used to establish the prospective class median rate.

(i) If the facility has an interim reimbursement rate as specified in (g), when the audit report is issued or when the cost report is deemed true and correct under Welfare and Institutions Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to August 1, 1996 to reflect the cost determined pursuant to such audit, or to reflect the cost in the cost report in the event that cost report is deemed true and correct.

(j) Interest will accrue from August 1, 1996 and be payable on any such underpayment or overpayment at a rate equal to the monthly average received on investment in the Surplus Money Investment Fund (as refer-

enced in the Welfare & Institutions Code Section 14171) during the month the audit report is issued.

(k) If a provider appeals an audit adjustment pursuant to Welfare & Institutions Code Section 14171, and there is a final determination that the audit findings inaccurately reflect the audited facility's projected costs, the provider shall be entitled to seek a retroactive adjustment in its reimbursement rate but the resulting reimbursement rate shall not exceed the prospective median rate as provided in subdivision (a).

(l) Payment under subsection (a) shall only be made for services authorized pursuant to conditions set forth in Section 51355.5 for patients determined to need subacute care services.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of 1996, Chapter 162, Items 4260-101-0001 and 4260-101-0890.

HISTORY

1. Certificate of Compliance as to 10-27-88 order including amendment of subsection (d) transmitted to OAL 2-24-89 and filed 3-27-89 (Register 89, No. 13). For prior history, see Register 89, No. 1.
2. Amendment filed 8-7-89 as an emergency; operative 8-7-89 (Register 89, No. 32). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 12-5-89.
3. Certificate of Compliance transmitted to OAL 12-1-89 and filed 1-2-90 (Register 90, No. 2).
4. Amendment filed 12-10-90 as an emergency; operative 12-10-90 (Register 91, No. 6). A Certificate of Compliance must be transmitted to OAL by 4-9-91 or emergency language will be repealed by operation of law on the following day.
5. Amendment of subsection (a) and heading filed as an emergency 3-14-91; operative 3-14-91 (Register 91, No. 14). A Certificate of Compliance must be transmitted to OAL by 7-12-91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 12-10-90 order transmitted to OAL 4-8-91 and filed 5-8-91 (Register 91, No. 24).
7. Amendment of subsection (c) and repealer of subsections (e) and (f) filed 5-21-91 as an emergency pursuant to Statutes of 1990, chapter 456, section 36, p. 1658-1659; operative 5-22-91 (Register 91, No. 27). A Certificate of Compliance must be transmitted to OAL by 9-19-91 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 3-14-91 order transmitted to OAL 7-11-91 and filed 8-9-91 (Register 91, No. 50).
9. Amendment of subsection (a) and NOTE filed 8-12-91 as an emergency; operative 8-12-91 (Register 92, No. 6). A Certificate of Compliance must be transmitted to OAL 12-10-91 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 8-12-91 order transmitted to OAL 12-9-91 and filed 1-2-92 (Register 92, No. 18).
11. Amendment of subsection (c) refiled 1-23-92 as an emergency; operative 1-17-92 (Register 92, No. 25). A Certificate of Compliance must be transmitted to OAL 5-22-92 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 1-23-92 order transmitted to OAL 5-22-92 and filed 7-6-92 (Register 92, No. 28).
13. Amendment of subsection (a) and NOTE filed 12-3-92 as an emergency; operative 12-3-92 (Register 92, No. 49). A Certificate of Compliance must be transmitted to OAL 4-2-93 or emergency language will be repealed by operation of law on the following day.
14. Certificate of Compliance as to 12-3-92 order transmitted to OAL 4-2-93 and filed 5-14-93 (Register 93, No. 20).
15. Amendment of subsection (a) and NOTE filed 8-24-93 as an emergency; operative 8-24-93 (Register 93, No. 35). A Certificate of Compliance must be transmitted to OAL by 12-22-93 or emergency language will be repealed by operation of law on the following day.
16. Amendment of subsection (a) and NOTE refiled 12-20-93 as an emergency; operative 12-20-93 (Register 93, No. 52). A Certificate of Compliance must be transmitted to OAL by 4-21-94 or emergency language will be repealed by operation of law on the following day.
17. Certificate of Compliance as to 12-20-93 order transmitted to OAL 3-22-94 and filed 4-28-94 (Register 94, No. 17).
18. Amendment of subsection (a), new subsections (e)-(f) and amendment of NOTE filed 10-16-95 as an emergency; operative 10-16-95 (Register 95, No. 42). A Certificate of Compliance must be transmitted to OAL by 2-13-96 or emergency language will be repealed by operation of law on the following day.
19. Editorial correction of HISTORY 18 (Register 96, No. 6).
20. Amendment of subsection (a), new subsections (e)-(f) and amendment of NOTE refiled 2-5-96 as an emergency; operative 2-5-96 (Register 96, No. 6). A Certificate of Compliance must be transmitted to OAL by 6-6-96 or emergency language will be repealed by operation of law on the following day.
21. Certificate of Compliance as to 2-5-96 order transmitted to OAL 6-4-96 and filed 7-12-96 (Register 96, No. 28).
22. Amendment of subsections (a), (e)-(g) and (i)-(j) and NOTE filed 9-19-96 as an emergency; operative 9-19-96 (Register 96, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-17-97 or emergency language will be repealed by operation of law on the following day.
23. Certificate of Compliance as to 9-19-96 order transmitted to OAL 1-17-97 and filed 3-3-97 (Register 97, No. 10).

§ 51511.6. Nursing Facility Services — Pediatric Subacute Care Reimbursement.

(a) The per diem rates of reimbursement for pediatric subacute services as defined in Section 51335.6(a) shall be as follows:

Licensure	*Type of Patient*	*Effective Until "7/1/97" for Alameda, Contra Costa Marin, San Francisco, San Mateo, Santa Clara Counties*	*Effective Until "7/1/97" for All Other Counties*	*Effective on 7/1/97 Statewide*
Hospital Based	Ventilator Dependent	[redacted]		
Hospital Based	Non Ventilator Dependent	[redacted]		
Free standing	Ventilator Dependent	[redacted]		
Free standing	Non-Ventilator Dependent	[redacted]		

(b) The per diem rate of reimbursement for supplemental rehabilitation therapy services shall b[redacted] This rate shall include payment for physical therapy, occupational therapy and speech therapy services provided in accordance with Section 51215.10(i) through (m).

(c) The per diem rate of reimbursement for ventilator weaning services shall be [redacted] This rate shall include respiratory care practitioner and nursing care services provided in accordance with Section 51215.11.

(d) Payment to nursing facilities with pediatric subacute units for patients on bedhold receiving acute services shall be in accordance with Section 51535.1(d).

(e) The provisions of Section 51511 shall apply to pediatric subacute units except for Section 51511(a). Section 51511(c) shall apply to pediatric subacute units except as provided for in 51511.6(f).

(d) The pediatric subacute per diem rate includes the following:

(1) Equipment and supplies necessary for continuous intravenous therapy;

(2) Oxygen and all equipment necessary for administration including positive pressure apparatus;

(3) Ventilators, including calibration and maintenance;

(4) Registered Dietician consultant services;

(5) Respiratory therapy services;

(6) Physical, occupational and speech therapy services, as specified in Section 51215.10(h);

(7) Developmental services;

(8) Service Coordinator activities.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of 1996, Chapter 162, Items 4260-101-0001 and 4260-101-0890.

HISTORY

1. New section filed 4-13-94 as an emergency; operative 4-1-94. Emergency adoption submitted to OAL for printing only pursuant to section 4, AB 36 (chapter 1030, Statutes of 1993) (Register 94, No. 15).
2. Certificate of Compliance as to 4-13-94 order including amendment of section transmitted to OAL 9-26-94 and filed 10-20-94 (Register 94, No. 42).
3. Editorial correction of subsection (d)(3) and HISTORY 1 and 2 (Register 95, No. 14).
4. Amendment of subsection (a) and NOTE filed 9-19-96 as an emergency; operative 9-19-96 (Register 96, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-17-97 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 9-19-96 order transmitted to OAL 1-17-97 and filed 3-3-97 (Register 97, No. 10).
6. Amendment of section and NOTE filed 6-30-97 as an emergency; operative 6-30-97 (Register 97, No. 27). A Certificate of Compliance must be transmitted to OAL by 10-28-97 or emergency language will be repealed by operation of law on the following day.

TN 98-015
Supersedes
TN _____

Approval Date 6/11/99

Effective Date August 1, 1998

OBRA 1987 Requirements for Nursing Facilities

Effective October 1, 1990

Comparison of Differences in OBRA 1987 Statutory Requirements, HCFA Regulations, and Current State Requirements

California Department of Health Services
Medi-Cal Policy Division

OBRA 1987 Requirement	HCFA Regulation (2/2/89)	Previous Federal Regulation	State Statute/Regulation	Analysis
Management of Personal Funds				
Management of personal funds - Upon a facility's acceptance of written authorization of a resident, the facility must manage and account for the resident's personal funds deposited with the facility as follows:	Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility ... (483.10(c)(2))	N/A	Each facility shall maintain safeguards and accurate records of a patient's monies and valuables entrusted to the facility's care, including the maintenance of a detailed inventory and at least a quarterly accounting of financial transactions made on the patient's behalf. (Title 22, 72529(a)(2))	Currently, management of a resident's personal funds is an optional facility service. Increased administrative cost for those facilities not currently managing patient trust accounts in accordance with OBRA provisions.
o Deposit - The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account that is separate from any of the facility's operating accounts and credits all interest earned to that account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.	The facility must deposit a resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's account to his or her account. (483.10(c)(3)(1))	N/A		

OBRA 1. Requirement	HCFA Regulation (2/2/89)	Previous Federal Regulation	State Statute/Regulation	Analysis
Nursing Facility Consolidation				
Required Nursing Care; and Facility Waivers - (1) General Requirements - With respect to NF services, a NF: o except as provided in (2) below, must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and o except as provided in (2) below, must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	Facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: o licensed nurses, except when waived, as specified below; o other nursing personnel; o facility must designate a licensed nurse to serve as charge nurse on each shift. (483.30(a)) RN - o Facility must use an RN for at least 8 consecutive hours a day, 7 days a week (except when waived as specified below). o Facility must designate an RN to serve as DNS on a full-time basis. o The DNS may serve as charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. (483.30(b))	SNF 405.1124 ICF 442.1124 442.338 442.342	For NFs licensed as SNFs: Nursing service personnel shall be employed and on duty in at least the number and with the qualifications determined by the Department to provide the necessary nursing services for patients admitted for care. (Title 22, 72329(a)) The Department may require the facility to provide additional professional, administrative or supportive personnel when the Department determines through a written evaluation that additional staff is needed to provide for the health and safety of patients. (Title 22, 72501(g)) - Facilities licensed for 59 or fewer beds shall have at least 1 RN or a licensed vocational nurse, awake and on duty, in the facility at all times, day and night. - Facilities licensed for 60 to 99 beds shall have at least 1 RN or LVN, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing. The director of nursing shall not have charge nurse responsibilities. - Facilities licensed for 100 or more beds shall have at least 1 RN, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing. The director of nursing shall not have charge nurse responsibilities. (Title 22, 72329(b,c,d)) Each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.0 nursing hours per patient day. (Title 22, 72393(f)) For NFs licensed as ICFs: - Nursing service personnel shall be employed in the num-	The increased staffing for licensed nurses will impact only NFs currently licensed as ICFs. ICFs will also require a medical director, as defined in OBRA. Because of more stringent state licensing standards, the licensed nurse staffing and medical director requirements will not impact NFs currently licensed as SNFs.
(2) Facility Waivers - o A state may waive the requirements in (1) above, if the facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts, to recruit appropriate personnel; if the state determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; and if the state finds that, for any such periods in which licensed nursing services are not available, an RN or physician is obligated to respond immediately to telephone calls from the facility. A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to	A facility may request a waiver from either the requirement that a facility provide an RN for at least 8 consecutive hours a day, 7 days a week, or the requirement that a facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in 483.30(a) above, if the following conditions are met: 1) The facility demonstrates to the satisfaction of the state that it has been unable, despite diligent efforts (including offering wages at the community prevailing rate for facilities), to recruit appropriate personnel; 2) The state determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; 3) The state finds that, for			

OBRA 1[illegible] Requirement	HCFA Regulation (2/2/89)	Previous
waiver authority by Secretary, shall be accepted to the same extent as is the state's certification of the facility. In granting or renewing a waiver, a state may require the facility to employ other qualified, licensed personnel.	any periods in which licensed nursing services are not available, an RN or physician is obligated to respond immediately to telephone calls from the facility; 4) A waiver granted under these conditions is subject to annual state review; and 5) In granting or renewing a waiver, a facility may be required by the state to use other qualified, licensed personnel.	
o If the Secretary determines that a state has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the state to grant waivers. (SSA, 1919(b)(4)(C))		

ber and with the qualifications determined by the Department to provide the necessary services for those patients admitted for care. The Department may require a facility to provide additional staff whenever the Department determines through a written evaluation of patients and patient care in the facility that such additional staff are needed to provide adequate nursing care and treatment or to provide for the safety of the patients.

- Facilities shall employ an RN or LVN 8 hours per day on day shift, 7 days per week. In case of facilities where an LVN serves as supervisor of health services, consultation shall be provided by an RN, through formal contract, at regular intervals, but not less than 4 hours weekly.

- Facilities with 100 or more beds shall employ an RN 8 hours per day, on the day shift, 7 days per week. In addition, an RN or LVN employed 4 hours per day, 7 days per week, during the day for each 50 beds or portion thereof in excess of 100.

- Nursing stations shall be staffed by nursing personnel day and night when patients are housed in the nursing unit.

(Title 22, 73319(a,b,c,d))

OBRA .	Requirement	HCFA Regulation (2/2/89)	Previo. ..eral Regulation	State Statute/Regulation	.alysis
N/A		Medical Director - The facility must designate a physician to serve as medical director. The medical director is responsible for: 1) implementation of resident care policies; and 2) the coordination of medical care in the facility. (483.75(k))	SNF 405.1122	Medical Director - The facility shall have a medical director who shall be responsible for standards, coordination, surveillance, and planning for improvement of medical care in the facility. The medical director shall act as a liaison between administration and attending physicians; be responsible for reviewing and evaluating administrative and patient care policies and procedures; act as a consultant to the Director of Nursing in matters relating to patient care services; and be responsible for reviewing employees' preemployment and annual health examination reports. (Requirement applies to Skilled Nursing Facilities) (Title 22, 72305)	

OBRA '.. Requirement	HCFA Regulation (2/2/89)	Previou. .deral Regulation	State Statute/Regulation	.nalysis
Social Worker				
Required Social Services - In the case of a facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services. (SSA, 1919(b)(7))	A facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. (483.15(g)(1)) A facility with more than 120 beds must employ a qualified social worker on a full-time basis. (483.15(g)(3)) Qualifications of a SW: A qualified social worker is an individual with: 1) Bachelor's Degree in social work; or 2) 2 years of social work supervised experience in a health care setting working directly with individuals; or 3) Similar professional qualifications. (483.15(g)(4))	SNF 405.1130 ICF 442.344(d) N/A N/A	A social worker is defined as: 1) clinical social worker (which requires a Master's Degree) - licensed by the California Board of Behavioral Science Examiners. 2) social work assistant - baccalaureate degree in the social sciences or related fields and who receives supervision, consultation and in-service training from a social worker. 3) social work aide - a staff person with orientation, on-the-job training, and who receives supervision from a social worker or social work assistant. (Title 22, 72105) Social Service Work Unit - Each social work service unit shall employ a staff for the number of hours to meet the needs of the patients. The social work service unit shall be organized, directed and supervised by a social worker, who is responsible for supervision of other social work staff, including social work assistants and social work aides. Social work service staff may include the social work assistant or the social work aide. Assigned functions and tasks shall be supervised by the social worker. Under conditions specified in the written patient care policies, procedures and job descriptions, the social work aide may be under the supervision of the social work assistant. (Title 22, 72437(a,b,c))	Increased staffing costs for those NFs with more than 120 beds to comply with Social Worker requirements, as defined in federal regulations.

OBRA ... Requirement	HCFA Regulation (2/2/89)	Previo... deral Regulation	State Statute/Regulation	...alysis
Nurse Aide Training				
Required Training of Nurse Aides -				
A NF must not use (on any basis) any individual who is not a licensed health professional as a nurse aide in the facility on or after 1/1/90, for more than 4 months unless the individual: o has completed a training and competency evaluation program, or a competency evaluation program, approved by the state, and o is competent to provide such services. (SSA, 1919(b)(5)(A))	Effective 1/1/90, a facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time, temporary, per diem, or other basis, unless: o that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the state, and o that individual is competent to provide nursing and nursing related services. (483.75(g)(1))	SNF 405.1124 ICF 442.342	A nurse assistant precertification training program shall be conducted by a SNF, agency, or public education institution whose precertification program meets state requirements and is approved by the Department. (Title 22, 72331(i)(1)) No precertification training program to be conducted by a facility shall be approved unless the program meets the following: 1) The program shall be started within 3 months of employment of an uncertified nurse assistant in that facility; and 2) The program shall be presented in its entirety and completed no later than 6 months from the date of employment of any uncertified nurse assistant in the program. (Title 22, 72311(i)(11)(A,B) A precertification training program shall consist of at least the following: 1) 100 hours of clinical practice under the direct supervision of the instructor or a licensed nurse which shall usually be conducted during normal working hours and which shall include demonstrations of theory and basic nursing skills. Return demonstrations by the student shall be under the immediate supervision of the instructor or a licensed nurse. During clinical practice, there shall be no more than 15 students to each instructor at any time. Clinical practice shall take place in a skilled nursing facility or intermediate care facility and shall be conducted concurrently with classroom instruction.	California's current Nurse Aide certification program is comparable with OBRA requirements in all areas except the time period in which NFs must require NAs to complete a facility-based training and certification program.
Current employees - A NF must provide, for individuals used as a nurse aide by facility as of 7/1/89, for a competency evaluation program approved by the state, and such preparation as may be necessary for the individual to complete such a program by 1/1/90. (SSA, 1919(b)(5)(B))	Effective 7/1/89, a facility must provide, for individuals used as nurse aides, a competency evaluation program approved by the state, and preparation necessary to complete the program by 1/1/90. (483.75(g)(2))	N/A		
Competency - The NF must not permit an individual, other than in a training and competency evaluation program approved by the state, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use the individual as a nurse aide unless the facility has inquired of the state registry (see 1919(e)(2)(A)) as to information in the registry concerning the individual. (SSA, 1919(b)(5)(C))	Effective 1/1/90, a facility must permit an individual to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competence only when 1) the individual is in a training and competency evaluation program approved by the state, and 2) the facility has asked and not yet evaluated a reply from the state registry for information concerning the individual. (483.75(g)(3))	N/A		
Re-training Required - If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed paid nursing or nursing-relat-	Effective 1/1/90, when an individual has not performed paid nursing or nursing-related services for a continuous period of 24 consecutive months since the most recent completion of a training and competency evaluation program, the facility must require the	N/A		

OBRA 1987 Requirement	HCFA Regulation (2/2/89)
ed services, the individual shall complete a new training and competency evaluation program. (SSA, 1919(b)(5)(D))	individual to complete a new training and competency evaluation program. (483.75(g)(4))

Previous Federal Regulation	State Statute/Regulation	Analysis
	2) 50 hours of classroom instruction which may be conducted in a SNF, ICF, or educational institution and shall consist of content and for the duration of hours as specified in state regulations... (Title 22, 72331(i)(19)(A,B))	
	A nurse assistant shall be certified by the Department if the nurse assistant has satisfactorily completed an approved precertification training program. The course instructor shall notify the Department in writing no later than 10 working days after the completion of each program of the names, current address and social security numbers of these nurse assistants who successfully completed the program. The notification shall include the dates on which the course began and ended and the signature of the course instructor. The Department shall then issue the certificate. (Title 22, 72331(j))	
	Expiration and Renewal - Nurse aide certificates shall be renewed every 2 years and renewal shall be conditional upon the certificate holder submitting documentation of completion of 24 hours of in-service training per year obtained through an approved training program or as approved by the state department. A certificate which is not renewed within 4 years after its expiration cannot be renewed, restored, reissued, or reinstated except upon completion of a certification program unless deemed otherwise by the state department... (H&S Code, 1337.6(a,h))	

OBRA 1 Requirement	HCFA Regulation (2/2/89)	Previous Federal Regulation	State Statute/Regulation	Analysis
Resident Assessment				
Requirement - A NF must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which a) describes the resident's capability to perform daily life functions and significant impairments in functional capacity; b) is based on a uniform minimum data set (MDS) specified by the Secretary; c) uses an instrument specified by the state; and d) includes the identification of medical problems. Certification - Each assessment must be conducted or coordinated by an RN who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment. Frequency - An assessment must be conducted promptly upon admission (within 14 days) and by not later than 10/1/91 for each current resident; promptly after a sigificant change in the resident's physical or mental condition; and in no case less often than once every 12 months. The NF must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment. Use - The results of the assessment shall be used in developing, reviewing, and revising the resident's plan of care.	The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. (483.20) Comprehensive assessment - The facility must make a comprehensive assessment of a resident's needs, which a) effective 10/1/90, is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the state; and b) describes the resident's capability to perform daily life functions and significant impairments in functional capacity. The comprehensive assessment must include at least the following information: o Medically defined condition and prior medical history; o Medical status measurement; o Functional status; o Sensory and physical impairments; o Nutritional status and requirements; o Special treatments or procedures; o Psychosocial status; o Discharge potential; o Dental condition; o Activities potential; o Rehabilitation potential; o Cognitive status; and o Drug therapy. (483.20(b)(1)) Accuracy of assessments - Each assessment must be conducted or coordinated, with the appropriate participation of health professionals. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (483.20(c)) (F-260-261)	SNF 405.1124(d) 405.1124(e) 405.1125 405.1129 405.1129(b) 405.1121(h) 405.1121(k)(5)	Nursing service shall include planning of patient care, including identification of care needs based upon an initial written and continuing assessment of the patient's needs with input from health professionals involved in the care of the patient. Initial assessments shall commence at the time of patient admission and be completed within 7 days of admission. (Title 22, 72311(a)(1)) Written and signed orders for diet, care, diagnostic tests and treatment of patients by others shall be required as a physician service in the facility. (Title 22, 72303(b)(5)) Planning of patient care shall include the development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. Care planning shall also include reviewing, evaluating, and updating of the patient care plan by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition. (Title 22, 72311(a)(1)(B,C))	It is California's understanding that HCFA will be promulgating its resident assessment instrument and the uniform MDS in regulation in the near future. California assumes the instrument and MDS will mirror the draft HCFA released in September 1990.

Miscellaneous One-Time Start-Up Expenses

Various OBRA provisions will require one-time implementation costs, such as forms development, computer software upgrades, and staff orientation and training.

ral Regulation	State Statute/Regulation	lysis
		Because of more stringent written notice requirements, documentation, medical recordkeeping, and resident assessment requirements, California recognizes facilities will need to make miscellaneous changes initially to implement OBRA, including staff orientation and training on the various new provisions.

OBRA 19(	Jirement	HCFA Regulation (2/2/89)	Previous F	Regulation	State Statute/Regulation	is
Resident Behavior and Facility Practices						
Restraints - Resident has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed a) to ensure the physical safety of the resident or other residents, and b) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.		The resident has the right to be free from any physical restraints imposed; or psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. (483.13(a))	405.1121(k)(7) 442.311(f)		Resident has the right to be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician or other person lawfully authorized to prescribe care for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others. (Title 22, 72527(a)(8)) Restraints of any type shall not be used as punishment, as a substitute for more effective medical and nursing care, or for the convenience of staff. (Title 22, 72319(d)) Written policies and procedures concerning the use of restraints and postural supports shall be followed. No restraints with locking devices shall be used or available for use. Restraints shall be used in such a way as not to cause physical injury to the patient and to ensure the least possible discomfort to the patient. Full documentation of the episode leading to the use of the physical restraint, the type of restraint used, the length of effectiveness of the restraint time and the name of the individual applying such measures shall be entered in the patient's health record. When drugs are used to restrain or control behavior or to treat a disordered thought process, the specific behavior or manifestation of disordered thought process to be treated with the drug is identified in the health record. (Title 22, 72319 (in part))	The existing California regulations are comparable and in some cases exceed the OBRA requirement. The OBRA statute and regulation impose no additional requirements. As a result, there is no added facility cost to comply with this OBRA provision.

OBRA 19 quirement	HCFA Regulation (2/2/89)	Previous F

Quality of Care and Quality of Life

Provision of Services and Activities -
To the extent needed to fulfill all plans of care described in 1919(b)(2), a facility must provide or arrange for the provision of:

o nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

o medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

o pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

o dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

o an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident; and

o routine dental services (to the extent covered under the state plan) and emergency dental services to meet the needs of each resident.

Quality of Care -
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) Activities of Daily Living (ADLs) - Based on the comprehensive assessment of a resident, the facility must ensure that:

1) a resident's abilities in ADLs do not diminish unless circumstances of the resident's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to:
(i) bathe, dress and groom;
(ii) transfer and ambulate;
(iii) toilet;
(iv) eat; and
(v) to use speech, language or other functional communication systems.

2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

3) A resident who is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
(483.25(a))

405.1124(e)
442.342
442.343(a),(c)

Regulation	State Statute/Regulation	
	Each patient shall be encouraged and/or assisted to achieve and maintain the highest level of self-care and independence. Every effort shall be made to keep patients active, and out of bed for reasonable periods of time, except when contraindicated by physician's orders. (Title 22, 72315(e))	In an analysis of the OBRA requirements, California has determined that current standards (in statute and regulation) are comparable to the OBRA requirements. As a result, no added facility cost is foreseen in order to comply with these OBRA quality of care and quality of life provisions.
	The supportive and restorative nursing and personal care needed to maintain maximum functioning of the patient shall be provided. (Title 22, 72315(f))	
	Nursing service personnel shall be employed and on duty in at least the number and with the qualifications determined by the Department to provide the necessary nursing services for patients admitted for care. The Department may require a facility to provide additional professional, administrative or supportive personnel whenever the Department determines through a written evaluation that additional staff is needed to provide for the health and safety of patients. (Title 22, 72319(a))	
	If a facility does not employ qualified personnel to render a specific service to be provided by the facility, there shall be arrangements through a written agreement with outside resources which shall meet the standards and requirements of these regulations. (Title 22, 72511(a))	
	Written arrangements shall be made for obtaining all necessary diagnostic and therapeutic services prescribed by the attending physician, podiatrist, dentist, or clinical psychologist .... If the ser-	

Regulation	State Statute/Regulation	/	s

vices cannot be brought into the facility, the facility shall assist the patient in arranging for transportation to and from the service location.
(Title 22, 72301(d))

PROJECTED COSTS
ASSOCIATED WITH NURSING HOME REFORM LEGISLATION
AS CONTAINED IN
THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA 87)

California Rate Year 1990/91

Rate Development Branch
Medi-Cal Policy Division
Department of Health Services

March, 1990

OBRA-87 COST ESTIMATES
(All Nursing Facilities)
California Rate Year 1990/91

SUBJECT	REQUIREMENT	COST PER PATIENT DAY 1/	PROJECTED MEDI-CAL DAYS 5/	ANNUAL MEDI-CAL COSTS
Protection of Resident Funds	Management of personal funds will be mandatory at patient discretion. Current regulations are optional.	NF/A&B = $ .21 DP NF/B = $ .46	21,865,000 2,135,000	$ 4,592,000 982,000
Nursing Facility Consolidation	Currently licensed freestanding Intermediate Care Facilities (ICFs) will require additional staffing to meet the higher level nursing facility certification requirements.	2/ NF/A = $ 2.51 NF/B = $ .00 DP NF/B = $ .00	1,155,000 0 0	$ 2,899,000 0 0
Social Services	Facilities with more than 120 beds must employ a full-time qualified social worker.	3/ NF/A&B = $ .44 DP NF/B = $ .33	8,365,000 1,535,000	$ 3,681,000 507,000
Resident Assessments	Facilities must conduct initially and periodically a comprehensive, standardized and reproducible assessment of each resident's functional capacity.	NF/A&B = $ .35 DP NF/B = $ .45	21,865,000 2,135,000	$ 7,653,000 961,000
	ESTIMATED OBRA ADJUSTMENTS	4/ $ .56 - 3.51	SUBTOTAL	$ 21,275,000

1/ Refer to pages 3 and 13 - 16 for calculations used in determining the costs per patient day.

2/ This cost per patient day adjustment is applicable only to nursing facilities currently licensed as Freestanding ICFs.

3/ These cost per patient day adjustments are applicable only to the 270 nursing facilities with more than 120 licensed beds.

4/ The cost per patient day adjustment will vary depending on whether the facility is currently licensed as a freestanding ICF and/or is in the 121+ bedsize category.

5/ Medi-Cal days are listed for only those facilities affected by each individual requirement. The total number of projected Medi-Cal days is 24,000,000.

OBRA-87 NURSE AIDE TRAINING AND ONE-TIME START-UP COST ESTIMATES
(All Nursing Facilities)
California Rate Year 1990/91

SUBJECT	REQUIREMENT	COST PER PATIENT DAY 1/	PROJECTED MEDI-CAL DAYS	ANNUAL MEDI-CAL COSTS
Nurse Aide Training	Facilities must not use any individual working in the facility as a nurse aide for more than four months, unless that individual has completed a training and competency evaluation program.	NF/A&B = $ .12 DP NF/B = $ .00	21,865,000 0	$ 2,624,000 0
One-time Start-up Costs	Facilities will incur one-time start-up costs to develop forms, upgrade computer software and provide staff orientation.	NF/A&B = $ .31 DP NF/B = $ .31	9,100,000 900,000	$ 2,821,000 $ 279,000

1/ Refer to pages 3 and 13 - 16 for calculations used in determining the cost per patient day.

OBRA-87 COST ESTIMATES
AVERAGE 99 BED NURSING FACILITY
(All Nursing Facilities)
California Rate Year 1990/91

SECTION	SUBJECT	TOTAL COST PER FACILITY [1/]	NUMBER OF FACILITIES	ESTIMATED OBRA COST	TOTAL PATIENT DAYS	COST PPD
483.10(c)	Protection of Resident Funds	$ 6,275	1,240	$ 7,781,000	37,000,000	$ .210
483.5 483.30 483.75(k)	Nursing Facility Consolidation - Staffing and Medical Director	---	34	$ 1,881,312	750,000	$ 2.508
483.15(g)	Social Services	$ 24,978	270	$ 6,744,060	15,500,000	$ .435
483.20(b)	Resident Assessment	$ 10,510	1,240	$ 13,032,400	37,000,000	$ .352
483.75(g)1	Nurse Aide Training	$ 3,625	1,240	$ 4,495,000	37,000,000	$ .121
n/a	One-time Start-up Costs	$ 3,805	1,240	$ 4,718,200	37,000,000	$ .310 [2/]

1/ Refer to pages 4 - 16 for calculations used to determine facility costs.

2/ The annualized cost PPD for one-time start-up costs is $ .128 ($4,718,200/37,000,000). $ .128 PPD will be adjusted to $ .310 ($ .128 x 12/5) to fully reimburse NFs during rate year 1990/91 (March 1, 1991 - July 31, 1991).

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Protection of Resident Funds (c)(2) Management of Personal Funds: Mandatory at Patient Discretion, (c)(3) Deposit of Funds: $50.00+ in Interest Bearing Accounts, $50.00 or less in non-interest bearing accounts, (c)(4) Accounting and Records: Separate Accounting Records, (c)(5) Notice of Balances: Within $200.00 of SSI Resource Limit, (c)(7) Assurances of Financial Security: Surety Bond,	50% of patients/families will request patient fund service involving both a formal interest bearing account and a petty cash account for immediate fund availability. Half of the residents will be in facilities that do not currently offer this service. The average 99 bed nursing facility has 91 patients x 130% patient turnover = 119 x 25% or 30 additional patient accounts.	40 minutes to establish each new account x 30 patients = 20 hours x cost of administrative staff @ $12.00 per hour = $240.00.	$ 240.00
		20 minutes per month to post each account x 30 accounts = 15.0 hours x $12.00 per hour = $180.00 x 12 months = $2,160.00.	$ 2,160.00
	Additional accounts will require an average of 20 minutes per month bookkeeper time to post and balance both the interest and non-interest bearing accounts. An additional 8 hours per month will be required to balance bank statements, prepare account balance records, provide records to patients, and notify patients if balance of personal funds is within the $200.00 SSI resource limit. Finally, it will require 30 minutes per day to make change from the petty cash fund for the daily needs of patients.	8 hours per month to balance/reconcile bank statements, provide records and SSI resource limit notice to patients, or 8 hours x $12.00 per hour = $96.00 x 12 months = $1,152.00.	$ 1,152.00
		30 minutes per day to make change x 365 days = 182.5 hours x $12.00 = $2,190.00.	$ 2,190.00
	The average balance of funds per patient is $300.00. In the average 99 bed facility, 23 patients will require additional surety bonds at any given time (91 patients x 50% = 46 patients requesting patient fund service x 50% of facilities without current bonding). The average surety bond is $12.50 per $1,000.00 of funds.	$300.00 x 23 patients = $6,900/$1,000 = 6.9 x $12.50 = $86.00.	$ 86.00

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
	Approximately 10% of all nursing facilities have computerized patient accounting systems. Approximately 75% of all nursing facilities are computerized. One time cost to automate patient accounting systems will be capitalized over a five year period.	1240 facilities x 90% = 1116 facilities who will need computer software to do patient accounting. $1,650 for software = $1,650 x 1116 facilities = $1,841,400. 25% of facilities will need hardware @ $3,000 x 310 facilities = $930,000. Average cost per facility = $1,841,400 (software) + $930,000 (hardware) = $2,771,400/1240 facilities = $2,235 average cost per facility. $2,235/5 year capitalized period = $447 per year.	$ 447.00

Cost to Establish New Account	=	$ 240.00
Cost to Update Each Account	=	2,160.00
Cost to Reconcile Statements	=	1,152.00
Cost to Make Change	=	2,190.00
Cost of Surety Bond	=	86.00
Automation Cost	=	447.00
Resident Fund Accounting Cost		**$ 6,275.00**

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Nursing Facility Consolidation Federal certification requirements will no longer distinguish between Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs). As a result, ICFs will require additional staffing to meet the higher level Nursing Facility (NF) certification requirements.	ICF services are provided exclusively in 34 freestanding facilities, averaging 60 beds per facility. With an occupancy rate of 98%, these facilities report 750,000 ICF patient days annually. It is estimated that 77% of all ICF patients, or 577,500 are Medi-Cal eligible. It is assumed all ICFs will remain as ICF facilities operating under current State licensing requirements. The provisions applicable to these facilities will be the upgrade from LVN to RN staffing on the weekend day shift, additional LVN staffing on the evening and night shift, and the addition of a medical director (28 of which already comply). It is assumed waivers will continue to be available for physical plant requirements. The additional RN staffing on the weekend day shift will affect 29 of the 34 facilities (facilities with less than 100 beds). It is estimated that 7 of the 29 ICFs are currently staffed with an RN on at least the day shift. It is also estimated that 10 of the 34 freestanding ICFs are staffed 24 hours per day with licensed nursing staff. Based on a survey of ICF facilities, it is assumed the remaining 24 facilities average 4.5 hours of LVN coverage during the evening or night shift.	Current RN hourly cost = $ 22.00 Minus LVN cost = (17.50) Net hourly cost = $ 4.50 x 8 hours per day x 8 Daily cost = $ 36.00 x 104 days annually x 104 Annual cost = $ 3,744 X 22 facilities x 22 $ 82,368	$ 82,368
		Current LVN cost = $ 17.50 x 11.5 hours per day x 11.5 Daily cost = $ 201.25 x 365 days annually = x 365 Annual cost = $ 73,456 x 24 facilities x 24 $1,762,944	$ 1,762,944

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
	A medical consultant contract will cost each of the six freestanding ICFs an estimated $500.00 per month. These facilities currently report 130,000 patient days (100,000 Medi-Cal patient days) annually.	Medical consultant contract @ $500.00 x 12 months = $6,000.00. $6,000.00 x 6 facilities = $36,000.00.	$ 36,000
	The remaining ICF patient days are provided in approximately 100 distinct parts of SNF facilities (DP/ICFs). The DP/ICFs already have RN staffing on weekends, 24 hour licensed nurse staffing and medical directors, as part of their SNF licensure. Since DP/ICF rates are based on freestanding ICF costs, the OBRA rate adjustment will impact all ICFs. DP/ICFs report 750,000 ICF patient days annually, of which 577,500 are Medi-Cal covered days.	Cost of RN on Weekend Day Shift =	$ 82,368
		Cost of 24 Hr. Licensed Nursing =	1,762,944
		Cost of Medical Director =	36,000
		Total ICF Cost	**$ 1,881,312**

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Social Services Each nursing facility must provide medically-related social services to attain or maintain the highest practicable physical, mental or psychosocial well-being of each resident. The new regulations require nursing facilities with more than 120 beds to employ a full-time qualified social worker. The qualifications of a social worker are: (1) a bachelor's degree in social work, or (2) two years of social work supervised experience in a health care setting working directly with individuals, or (3) similar professional qualifications.	There are approximately 270 nursing facilities with more than 120 beds. The average facility in this category has 168 beds and reports approximately 53,600 patient days per year. It is estimated that 20% of all facilities with more than 120 beds currently employ a full-time qualified social worker.	1.0 full-time social worker = 2080 hours per year @ $15.00 per hour (including employee benefits) = $31,200.00 per year. $31,200.00/53,600 patient days annually = $ .582 per patient day x 80% (facilities with more than 120 beds and without a full-time qualified social worker) = a net cost increase for all facilities with more than 120 beds of $ .466 per patient day. $ .466 x 53,600 patient days annually = $24,978.00.	$ 24,978.00
		Total Social Worker Cost	**$ 24,978.00**

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Resident Assessment Upon Admission *Nursing facilities must conduct* initially and periodically (see below) a comprehensive, accurate, *standardized, reproducible* assessment of each resident's functional capacity. The assessment instrument will be specified by the State and shall include a minimum data set, as defined by the Health Care Financing Administration.	Each nursing facility must assess 120 new admissions annually and will require 1.0 hour of RN time.	1.0 hour of RN time @ $22.00 x 120 assessments = $2,640.00.	$ 2,640.00
	Each assessment will require 1.0 hour of staff support per assessment. This staff includes dietary, CNAs, social services and/or activities staff.	1.0 hour of staff support @ $10.00 x 120 assessments = $1,200.00.	$ 1,200.00
		6.0 hours of DSD time @ $18.00 per hour = $108.00.	$ 108.00
	The DSD to conduct training on the resident assessment process and documentation requirements. Two 3.0 hour classes, or 6.0 hours per year. Additional 3.0 hours per year for RNs and CNAs to attend training.	The average training class hours will involve RNs (15 hours) and CNAs (20 hours) = 35 total staff hours. The weighted average cost per hour = 15 x $22.00 + 20 x $7.50 = $480.00/35 hours or $13.71 per hour. Twice a year training, or 70 hours x $13.71 per hour = $960.00.	$ 960.00
			$ 4,908.00
		Current assessment cost = 1/5 of projected cost, or $982.00.	($ 982.00)
			$ 3,926.00
		Average cost to conduct each resident assessment = $4,908.00/120, or $40.90.	

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Resident Assessment After Significant Change in Condition Assessments must be conducted promptly after a significant change in resident's physical or mental condition.	Each patient (120 throughout the year) will have one significant change in condition. This assessment will only require 1/3 of the time necessary to complete the initial resident assessment.	120 assessments x $13.63 (1/3 of $40.90) = $ 1,636.00	$ 1,636.00
Annual Resident Assessment Assessments must be conducted no less often than once every twelve months.	25% of patients require annual assessments or 30 annual assessments. Average cost per assessment = $40.90.	30 annual assessments x $40.90 = $ 1,227.00.	$ 1,227.00
Quarterly Review of Resident Assessments Nursing facilities must examine each resident no less than once every 3 months and, as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	Quarterly reassessments will take 1/3 the time to complete the new resident assessment criteria and cost an estimated $13.63 per assessment. Since an annual assessment is required, only 3 quarterly assessments are needed per year. Average of 91 patients year round.	91 patients x 3 reassessments = 273 reassessments x $13.63 per assessment cost = $ 3,721.00.	$ 3,721.00

Cost of RA - Admission	$ 3,926.00
Cost of RA - Change in Condition	1,636.00
Cost of RA - Annual Assessment	1,227.00
Cost of RA - Quarterly Review	3,721.00
Total Resident Assessment Cost	**$10,510.00**

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Required Training of Nurse Aides Nursing facilities must not use any individual working in the facility as a nurse aide for more than four months, on a full-time, temporary, per diem or other basis, unless (1) that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State, and (2) that individual is competent to provide nursing and related services.	Nurse aides are currently required to complete their 150 hour certification program within six months of the date of employment. Nursing facilities who operate an approved facility based program conduct an average of four certification classes each year. The new requirement that nurse aides complete their training within four months will require two additional certification programs per year.	2 new 150 hour certification programs = 300 hours + 25% of class time for preparation and administration = 375 hours. 375 hours of DSD time @ $18.00 per hour = $ 6,750.00.	$ 6,750.00
		Additional training supplies and equipment = $ 500.00.	$ 500.00
			$ 7,250.00
	Half of all nursing facilities operate a facility based certification program, while the other half refer their nurse aides to community based certification programs, such as community colleges or regional occupational programs.	Current community based program costs = 1/2 of projected costs, or $3,625.00.	($ 3,625.00)
			$ 3,625.00
		Total Nurse Aide Training Cost	$ 3,625.00

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Nursing facilities will incur one-time start-up costs to develop and distribute additional resident notices, upgrade computer software and to provide staff orientation.	Resident notices must be in writing. Current industry practice is typically a telephone or personal discussion. Resident notices will require 40 hours of RN time and 40 hours of administrative staff time to develop new forms and processing procedures. It is assumed the facility will need to make available 4,400 copies of necessary notices.	40 hours of RN time @ $22.00 per hour = $880.00. 40 hours of administrative staff time @ $12.00 per hour = $480.00. 4,400 copies @ $ .05 per copy = $220.00. Total cost to develop forms ($880.00 + $480.00 + $220.00).	$ 1,580.00
	Upgrade of computer software will vary, but average $900.00 per nursing facility.	One-time cost for computer upgrade/software.	$ 900.00
	RN staff must provide the equivalent of one day of training to 2 LVNs and 9 administrative staff.	8 hours of RN time @ $22.00 per hour = $180.00. 16 hours of LVN time @ $17.50 per hour = $280.00. 72 hours of administrative staff time @ $12.00 per hour = $865.00. Total cost to provide staff orientation ($180.00 + $280.00 + $865.00).	$ 1,325.00

Cost to Develop Forms	=	$ 1,580.00
Cost for Computer Upgrade	=	900.00
Cost for Staff Orientation	=	1,325.00
Total One-Time Costs		**$ 3,805.00**

VARIATION IN ASSUMPTIONS AND COSTS FOR HOSPITAL-BASED DISTINCT PART FACILITIES VS THE AVERAGE 99 BED NURSING FACILITY

Subject: Protection of Resident Funds

Assumptions

No Hospital-based Distinct Part Nursing Facilities (DP NFs) currently offer resident fund service (vs 50% for the "average 99 bed" Nursing Facility (NF) used in cost calculations), so the relative number of additional trust accounts will be doubled.

Patient turnover is 2.5 times as high for Medi-Cal patients in DP NFs as for all patients in the NF, so proportionately more new trust accounts will need to be set up and more surety bonds will need to be paid.

Additionally, since no DP NFs currently have patient trust accounts, none of them will have computerized patient accounting systems (vs 10% of the NFs) and all will need software.

All DP NFs (vs 75% of NFs) are computerized, so none will need to buy hardware. However, most are tied to a larger central computer with more costly software, not readily reprogrammed for patient trust account transactions. Software purchases and modifications will be approximately three times as costly.

All other assumptions are the same.

VARIATION IN ASSUMPTIONS AND COSTS FOR HOSPITAL-BASED DISTINCT PART FACILITIES VS THE AVERAGE 99 BED NURSING FACILITY

Subject: Protection of Resident Funds (continued)

Cost Impact

The cost of patient fund service for NFs is modified as follows for DP NFs:

2 x 2.5 x $240.00 = $1,200.00, an increase of $960.00 to establish new accounts.

2 x $2,160.00 = $4,320.00, an increase of $2,160.00 to update each account.

2 x $1,152.00 = $2,304.00, an increase of $1,152.00 to reconcile statements.

2 x $2,190.00 = $4,380.00, an increase of $2,190.00 to make change.

2 x 2.5 x $86.00 = $430.00, an increase of $344.00 for surety bonds.

1.00/0.90 x $1,485.00 x 3 = $4,950.00, an increase of $3,465.00 for software or $693.00 per year capitalized over five years.

Elimination of the need to purchase hardware at an average cost of $750.00, or $150.00 per year capitalized over five years.

The net change is:

Establish New Account	$ 960.00
Update Each Account	2,160.00
Reconcile Statements	1,152.00
Make Change	2,190.00
Surety Bonds	344.00
Automation - Software	693.00
- Hardware	(150.00)
	$7,349.00

The overall facility cost of $6,275.00 for NFs will increase by $7,349.00 or 117.1% for DP NFs. So, the cost per patient day will increase by 117.1% from $.21 to $.46 for DP NFs.

VARIATION IN ASSUMPTIONS AND COSTS FOR HOSPITAL-BASED DISTINCT PART FACILITIES VS THE AVERAGE 99 BED NURSING FACILITY

Subject: Resident Assessments

Assumptions

Patient turnover is 2.5 times as high for Medi-Cal patients in DP NFs as for all patients in NFs. Therefore, 2.5 times as many initial assessments upon admission will need to be done, but the number of assessments after a change in condition will not be different. Because patients do not stay as long on the average in DP NFs, only one fourth as many annual assessments will be required and one half as many quarterly reviews.

All other assumptions are the same.

Cost Impact

The cost of resident assessments for NFs is modified as follows for DP NFs:

2.5 x $3,926.00 = $9,815.00, an increase of $5,889.00 for assessments upon admission.

0.25 x $1,227.00 = $306.75, a decrease of $920.25 for annual assessments.

0.50 x $3,721.00 = $1,860.50, a decrease of $1,820.50 for quarterly reviews.

The net change is:

RA - Admission	$ 5,889.00
RA - Change in Condition	0.00
RA - Annual Assessment	(920.25)
RA -Quarterly Review	(1,860.50)
TOTAL	$ 3,108.25

The overall facility cost of $10,510.00 for NFs will increase by $3,108.25 or 29.6% for DP NFs. So the cost per patient day will increase by 29.6% from $.35 to $.45 for DP NFs.

VARIATION IN ASSUMPTIONS AND COSTS FOR HOSPITAL-BASED DISTINCT PART FACILITIES VS THE AVERAGE 99 BED NURSING FACILITY

Subject: Social Services

Assumptions

Of DP NFs with more than 120 beds, 40% currently employ a full-time qualified social worker (vs 20% for NFs).

Cost Impact

The cost to add a full-time social worker is modified as follows for DP NFs:

0.60/0.80 x $24,978.00 = $18,733.50, a decrease of $6,244.50 or 25.0%.

The overall facility cost of $24,978.00 for NFs will decrease by $6,244.50 or 25.0% for DP NFs. So the cost per patient day will decrease by 25.0% from $.44 to $.33 for DP NFs.

Subject: Nurse Aide Training

Assumptions

Among DP NFs, no facilities now do training programs (vs half of the NFs), and none of the DP NFs will institute them. Relatively fewer nurse assistants are hired in DP NFs and a greater percentage are already certified, so fewer new hires will need training and those who do will be trained in outside training programs.

Cost Impact

The additional cost to train nurse aides is estimated to be zero for DP NFs.

APPENDIX C

NURSING FACILITY RATE COMPARISON
(Rate Year 1989/90, Rate Year 1990/91 (PRE-OBRA '87), AND ESTIMATED RATE YEAR 1990/91 (WITH PROPOSED OBRA '87 ADJUSTMENTS))

1989/90 Peer Groups	1989/90 Rates	1990/91 Peer Groups (Pre-OBRA)	1990/91 Rates (Pre-OBRA)	1990/91 Peer Groups (With Proposed OBRA Adjustments)	Estimated 1990/91 Rates (With Proposed OBRA Adjustments)
SNF 1-59 LA	$ 61.18	SNF 1-59 LA	$ 63.75	NF (Level B) 1-59 LA	$ 64.74
" " BA	66.96	" " BA	70.02	" " " " BA	71.01
" " AO	62.23	" " AO	64.88	" " " " AO	65.87
					1/
SNF 60+ LA	56.66	SNF 60+ LA	61.41	NF (Level B) 60+ LA	62.40 1/
" " BA	66.56	" " BA	74.26	" " " " BA	75.25 1/
" " AO	60.41	" " AO	65.06	" " " " AO	66.05
					2/
DP/SNF (max. rate)	183.97	DP/SNF (max. rate)	192.04	DP/NF (max. rate)	193.26
ICF 1-99 LA	47.40	ICF 1-99 LA	49.72	NF (Level A) 1-99 LA	53.22
" " BA	47.40	" " BA	49.72	" " " " BA	53.22
" " AO	44.13	" " AO	44.84	" " " " AO	48.34
					1/
ICF 100+ LA	43.17	ICF 100+ LA	44.49	NF (Level A) 100+ LA	47.99 1/
" " BA	43.17	" " BA	44.49	" " " " BA	47.99 1/
" " AO	43.17	" " AO	44.49	" " " " AO	47.99
ICF/DD 1-59	78.28	ICF/DD 1-59	85.08	ICF/DD 1-59	85.08
" 60-299	62.01	" 60-299	69.67	" 60-299	69.67
" 300+ (max. rate)	181.33	" 300+ (max. rate)	205.89	" 300+ (max. rate)	205.89
ICF/DDH 4-6	94.12	ICF/DDH 4-6	106.09	ICF/DDH 4-6	106.09
" 7-15	86.21	" 7-15	102.60	" 7-15	102.60
ICF/DDN 4-6	121.61	ICF/DDN 4-6	130.06	ICF/DDN 4-6	130.06
" 7-15	112.35	" 7-15	124.94	" 7-15	124.94
Subacute Hosp. Vent.	332.35	Subacute Hosp. Vent.	351.47	NF (Level B) Subacute Hosp. Vent.	352.69
" Free. Vent.	220.38	" Free. Vent.	233.23	" " " " Free. Vent.	234.22
" Hosp. Non-Vent.	313.94	" Hosp. Non-Vent.	332.19	" " " " Hosp. Non-Vent.	333.41
" Free. Non-Vent.	201.99	" Free. Non-Vent.	213.98	" " " " Free. Non-Vent.	214.97

1/ Nursing facilities (Level A or B) with more than 120 beds will receive an additional $ .44 PPD.

2/ Hospital based nursing facilities with more than 120 beds will receive an additional $ .33 PPD.

APPENDIX D

Report No. 01-89-01

Reimbursement Study:

Skilled Nursing and Intermediate Care Services

Rate Development Branch
Medi-Cal Policy Division
Department of Health Services

July, 1989

DEPARTMENT OF HEALTH SERVICES REPORT

This study establishes Medi-Cal (Medicaid) reimbursement for skilled nursing facilities (SNFs) including subacute services, intermediate care facilities (ICFs), intermediate care facilities for the developmentally disabled (ICF/DDs), and SNFs with special treatment program (STP) services as required by Section 249 of Public Law 92-603, and complies with state legislation and the requirements of the Medi-Cal program. Reimbursement rates for intermediate care facilities for the developmentally disabled-habilitative (ICF/DD-H) and intermediate care facilities for the developmentally disabled-nursing (ICF/DD-N) facilities are established in separate studies, under Section V page 7 of the State Plan Attachment 4.19-D.

SUMMARY OF METHODOLOGY

1. Collected data from cost reports submitted to the Office of Statewide Health Planning and Development (OSHPD) and to the Department's Audits and Investigation Division (A&I) and distributed it to the appropriate reimbursement category by level of care, bed size class, and geographic area where applicable.

2. Applied an adjustment when SNFs reported ICF days, but did not separate ICF and SNF costs. This converted ICF days to SNF days in order to standardize the calculations.

3. Applied an adjustment to all facilities in the universe, reflecting the difference between reported and audited costs and patient days for field audited facilities. The adjustment included an allowance for settled appeals.

4. Updated each facility's adjusted costs from the midpoint of its fiscal year through January 31, 1990, the midpoint of the State's 1989-90 Rate Year, to bring all costs to a common base period. For this purpose, the reported costs were separated into the categories of (1) fixed or capital related costs; (2) property taxes; (3) labor costs; and (4) all other costs.

5. Determined prospective class median rates for each category of reimbursement based on projected costs for each facility.

METHODOLOGY

Data Collection

The Department received cost reports from 1,191 long term care facilities. Data from these cost reports were used for this study. Some cost data may have been excluded from the study because facilities either failed to submit a report on a timely basis or received permission from OSHPD to file a late report.

All cost reports in the universe had fiscal year endings in the State's 87-88 Fiscal Year. After checks for accuracy and completeness of data, the data sheets were keypunched for entry into the computer system. Each data record contained the following elements:

1. Provider number
2. Facility number and address
3. An assigned identification number
4. State facility number (county code)
5. Licensed bedsize
6. Type of ownership (profit, non-profit)
7. Fiscal period
8. Total patient days by level of care
9. Total Medi-Cal patient days by level of care
10. Total reported costs by level of care
11. Total plant operations
12. Plant operations by level of care
13. Fixed or capital related costs
14. Property tax where identified
15. Facility type: freestanding or distinct part of an acute care facility

Audit Adjustment

This adjustment accounts for the difference between reported and audited costs and patient days. Because of the time lag in performing field audits, it was necessary to use the 1987 calendar year field audit findings for this computation.

The randomly selected field audits were performed in accordance with regulations dealing with reasonable and patient related costs as published in Title XVIII of the Social Security Act (Medicare) and Title 22, Division 3, California Code of Regulations. Primary audit guidelines came from the federal Department of Health and Human Services Manual (HCFA 15-1).

In accordance with the field audit requirements, there could be no less than 15 percent of facilities in each of the 1-59 and 60+ bedsize groups selected to develop the audit percentage adjustments. This produced samples of SNFs sufficiently large to produce an audit ratio with 90 percent confidence that did not deviate from the estimated class population by more than 2 percent.

For ICFs and ICF/DDs, there are relatively few facilities in their groups, so the entire universe was audited. Then, where available, facility specific audit adjustments were applied. For facilities who, for some reason, had no audit, the average for their group was computed and applied.

The adjustments were calculated as the simple average of the ratio of audited costs and days to reported costs and days. A computation from settled appeals of cost report audits used in prior rate studies was used to obtain final ratios. The SNF 60-299 bedsize has been combined with the 300+ bedsize and the audit adjustment for this group was applied to the DP/SNF category. The audit average adjustments were:

Bedsize	Ratios
SNF 1-59	.95288
SNF 60 + and DP/SNFs	.95655

ICF Adjustment

An adjustment was made for the differential between SNF costs and ICF costs that were not segregated by the facilities reporting ICF days. The reported ICF days were multiplied by .6871 (the historical ratio of ICF to SNF costs) to equate ICF days to SNF days. The total cost was then divided by the adjusted total patient days to determine SNF cost per patient day.

Cost-of-Living Update

Adjusted costs for each facility were updated from the midpoint of the facility's fiscal year through January 31, 1990.

Adjusted costs were divided into categories and treated as follows:

1. Fixed or Capital Related Costs - These costs represent depreciation, leases and rental, interest, leasehold improvements, and other amortization. As these costs remain relatively constant over a number of years, there was no logical basis to update costs in this category.

2. Property Taxes - These costs, where identified, were updated at a rate of two percent annually converted to a monthly basis of .1667 percent per month. The basis for this adjustment was that Proposition 13 limits property tax increases to two percent a year, except where property is reassessed upon sale.

   Some facilities did not report property taxes, either because they were nonprofit and exempt from such tax, or because they had a lease or rental agreement that included those costs.

3. Labor Costs - A ratio of salary, wage and benefit costs to the total costs of each facility was used to determine the amount of the labor cost component to be updated. This ratio was determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report. Benefits were added that represent all wage related benefits including vacation and sick leave. The final ratios were: .6550 for SNF's, .5774 for ICFs, and .6645 for ICF/DD's.

   A table of factors was developed to update labor costs for each facility from the midpoint of its cost reporting period to the midpoint of the state's rate year (January 31, 1990). This table used industry specific wage data reported by the facilities through December 31, 1988 to the state's Employment Development Department. The data were then projected to the midpoint of the State's rate year, January 31, 1990.

4. All Other Costs - These costs are the total costs less fixed or capital related costs, property taxes, and labor costs. The update for "All Other Costs" utilized the California Consumers Price Index (CCPI) for "All-Urban Consumers", and figures projected by the Department of Finance through January 31, 1990.

Subacute Services of Skilled Nursing Care

Payment for subacute services in SNFs continues to be based largely on the original reimbursement model due to lack of sufficient cost data from participating facilities.

Increments for Increase in Licensure Fees

An amount was added to the updated cost of each facility for increases in licensure fees which were effective July 1, 1988 and 1989.

Increment for the State's New Minimum Wage Program

Salaries, wages and benefits were updated to reflect the July 1, 1988 increase in the state minimum wage requirements. Added to the updated facility costs was a per diem adjustment which varied by facility level of care, geographical location and bedsize category as determined by the department's study entitled "Long-Term Care Minimum Wage Study" - - Report No. 01-88-02.

Adjustment for OBRA Personal Hygiene Items

The updated cost of each facility was adjusted to include the costs of certain personal hygiene items, as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987. Added to the updated facility costs was a per diem adjustment which varied by facility level of care as determined by the department's study entitled "Study to Determine the Cost of Providing OBRA Personal Hygiene Items" - Report No. 01-89-02.

Class and Median Determination

For SNF's, ICF's and SNF-STP's, classes were grouped by bedsize and three geographical locations: (1) Los Angeles, (2) the six Bay Area counties; Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara, and (3) all other counties. Classes for ICF/DD's were established by bedsize and level of care on a statewide basis, as there was an insufficient number of facilities for geographical groupings. The DP/SNF and ICF/DD 300+ bedsize classes were also determined on a statewide basis by level of care.

RECOMMENDED RATES (August 1989)

Payment to facilities providing skilled nursing and/or intermediate care are recommended as follows:

Rates for SNF Services

Bedsize	Los Angeles County	Alameda, Contra Costa, Marin, San Francisco, San Mateo & Santa Clara Counties	All Other Counties
1-59	$61.18	$66.96	$62.23
60 +	$56.66	$66.56	$60.41

For SNFs that are distinct parts of acute hospitals, regardless of geographical location, the lesser of costs as projected by the Department or the prospective class median rate of $183.97.

Rates for Subacute Services of Skilled Nursing Care

	Freestanding Facility	Hospital-Based Facility
Ventilator Dependent Patient	$220.38	$332.35
Other Subacute Patients	$201.99	$313.94

Rates for ICF Services

Bedsize	Los Angeles County	Alameda, Contra Costa, Marin, San Francisco, San Mateo & Santa Clara Counties	All Other Counties
1-99	$47.40	$47.40	$44.13
100+	$43.17	$43.17	$43.17

Rates for ICF/DD Services

	Bedsize 1-59	60-99	100-299
Range A	$74.53	$58.66	$57.36
Range B	$78.28	$62.01	$62.01

	60-99 With 1-59 Distinct Part	100+ With 1-59 Distinct Part	100+ With 60-99 Distinct Part
Range A	$59.90	$58.65	$58.55
Range B	$62.01	$62.01	$62.01

ICF/DDs with the licensed bed capacity of 300 or more beds shall be entitled to payment for services at the lesser of costs as projected by the Department or the prospective class median rate of $181.33.

Special Treatment Program Services for the Chronic Mentally Disordered

The rate for a supplemental payment to SNF and ICF providers for services to the chronic mentally disordered, as defined in Section 51511.1, Title 22, CCR, will remain at $5.72 per patient day.

Rural Hospital Swing Bed Rates

Reimbursement is established at the prospective class median rate of all SNF nonsubacute distinct parts of rural acute care hospitals which participate in the Medi-Cal program. This rate is $133.71.

Leave of Absence and Bed Hold Rates

Payment is reduced when the patient is on leave of absence or for bed hold as authorized by Sections 51535 and 51535.1, Title 22, CCR. The lesser payment is accounted for by savings in the raw food and dietary costs. The reduction in rates will be $3.28 per patient day, based on the average of the Los Angeles and San Francisco area increases listed in the CPI Selected Areas "Food at Home Costs".

ultimately determined by the department to be due shall be reduced by 10 percent for each 30-day period, or portion thereof, that the hearing or the decision, or both, are delayed beyond the time limitations provided in subdivisions (f) and (g). However, the time period shall be extended by either of the following:

(1) Delay caused by a provider.

(2) Extensions of time granted a provider at its sole request or at the joint request of the provider and the department.

(f)(1) Notwithstanding subdivision (c), the administrative appeal process established by the director shall commence with an informal conference with the provider, a representative of the department, and the administrative law judge. The informal conference shall be conducted no later than 90 days after the filing of a timely and specific statement of disputed issues by the provider. The administrative law judge, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. The review conducted at this informal level shall be completed no later than 180 days after the filing of a timely and specific statement of disputed issues by the provider.

(2) Nothing in this subdivision shall prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (c). The impartial hearing shall be conducted no later than 300 days after the filing of a timely and specific statement of disputed issues by the provider. For noninstitutional providers, a proposed decision shall be prepared and transmitted to the director and the parties within 60 days after the closure of the record of the impartial hearing. For institutional providers, a proposed decision shall be prepared and transmitted to the director and the parties within 180 days after the closure of the record of the impartial hearing.

(3) Subject to subdivision (g), a final decision in a noninstitutional provider appeal shall be adopted within 180 days after the closure of the record of the impartial hearing, and a final decision in an institutional provider appeal shall be adopted within 300 days after the closure of the record of the impartial hearing.

(g) In the event the director intends to modify a proposed decision, on or before the 180th day following the closure of the record of the hearing for noninstitutional providers or the 300th day following the closure of the record of the hearing for institutional providers, the director shall provide written notice of his or her intention to the parties and shall afford the parties an opportunity to present oral and written argument. Following this notice, on or before the 240th day following the closure of the record of the hearing for noninstitutional providers or the 420th day following closure of the record of the hearing for institutional providers, or within that additional time period as is granted pursuant to the sole request of a provider or at the joint request of the provider and the department, the director shall issue a modified decision.

(h) In the event recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of a disallowed payment shall be entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, commencing on the date the appeal is formally accepted by the department or the date payment is received by the department, whichever is later.

(i) Commencing 60 days after issuance of the first statement of account status or demand for repayment resulting from an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund during the month the first statement of account status or demand for repayment was issued shall be assessed against any unrecovered overpayment due to the department.

(j) The final decision of the director shall be reviewable in accordance with Section 1094.5 of the Code of Civil Procedure within six months of the issuance of the director's final decision.

(Added by Stats.1977, c. 1046, p. 3172, § 6. Amended by Stats.1978, c. 429, § 248.2, eff. July 17, 1978, operative July 1, 1978; Stats.1979, c. 373, § 388; Stats.1981, c. 102, p. 747, § 130, eff. June 28, 1981; Stats.1981, c. 1163, p. 4661, § 18, eff. Oct. 2, 1981; Stats.1982, c. 842, p. 3174, § 2; Stats.1983, c. 900, § 1; Stats.1985, c. 1333, § 4; Stats.1986, c. 562, § 2; Stats.1987, c. 56, § 188; Stats.1988, c. 1079, § 1.)

Historical and Statutory Notes

The 1978 amendment deleted former subd. (b) which had read:

"(b) The director shall contract with the Department of Benefit Payments to conduct hearings or other proceedings and to prepare proposed decisions for adoption by the director pursuant to such regulations."; it relettered the remaining subdivisions; in subd. (b) [now subd. (c)], in the first sentence, it substituted "department" for "Department of Benefit Payments" and in the second and third sentences substituted "director" for "Director of Benefit Payments"; and in subd. (c), formerly (d) [now subd. (f)], references to former subd. (c) were corrected to refer to subd. (b).

The 1979 amendment, in subd. (a), substituted "10722" for "14102"; and in subd. (b) [now subd. (c)] first sentence, it substituted "10722 and 14170" for "14102 and 14105."

The 1981 amendment by c. 102, § 130, added subd. (d) [now subd. (h)], relating to interest rates applicable to the recovery of a disallowed payment, and subd. (e) [now subd. (i)], relating to the interest rate to be assessed against unrecovered overpayments; and, redesignated the subdivisions accordingly.

Application of provisions of Stats.1981, c. 102 which are in conflict with federal statutes or regulations, see Historical and Statutory Notes under § 10020.

The 1981 amendment by c. 1163, § 18, in subd. (d), [now subd. (h)], inserted "whichever is later" to the end of the provisions relating to interest rates on recovery of disallowed payments and rewrote subd. (e) [now subd. (i)], which previously read:

"Commencing 60 days after issuance of the first statement of accountability or demand for repayment resulting from an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate equal to the rate received on investments in the Pooled Money Investment Fund shall be assessed against any unrecovered overpayment due to the department."

The 1982 amendment substituted "monthly average" for "rate" preceding "received on investments" in subd. (d) [now subd. (h)].

The 1983 amendment in subd. (c) [now subd. (f)] in the first sentence inserted "for institutional providers" following "by the director"; inserted subd. (d); and redesignated former subds. (d), (e), and (f) as subds. (e), (f), and (g) respectively.

The 1985 amendment rewrote subd. (a); inserted subd. (b); relettered former subd. (b) as subd. (c); rewrote the first sentence of subd. (c) which had read:

"The administrative appeal process established by the director shall guarantee a provider the right to present any grievances or com-

plaints arising from the findings of an audit or examination made by or on behalf of the department pursuant to Sections 10722 and 14170 at an impartial hearing which shall include the procedural requirements of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Title 2 of the Government Code."; inserted a new subd. (d); and relettered former subds. (c) through (g) to be subds. (e) through (i).

The 1986 amendment substituted "administrative law judge" for "hearing officer" throughout the section; inserted subd. (e) relating to mandatory time limitations; relettered the remaining subdivisions; increased the numbers of days within which appeals occur in subd. (g); and made nonsubstantive changes.

The 1987 amendment substituted, in subds. (h) and (i), "Surplus Money Investment Fund" for "Pooled Money Investment Fund"; and made non-substantive changes to maintain the codes.

The 1988 amendment, in subds. (c) and (d) substituted "Code of Regulations" for "Administrative Code"; and rewrote subds. (e) to (g) which had read:

"(e) The time limitations in subdivision (g) for the impartial hearing and the final decisions are mandatory. If the department fails to conduct the hearing within 360 days or to adopt a final decision thereon within 180 days of the hearing, the amount of any overpayment which is ultimately determined by the department to be due shall be reduced by 10 percent for each 30-day period that either the hearing or the decision, or both, are delayed beyond 360 days or the additional 180 days provided in subdivision (g). However, the time period shall be extended by either of the following:

"(1) Delay caused by a noninstitutional provider.

"(2) Extensions of time granted a noninstitutional provider at its sole request or at the joint request of the provider and the department.

"(f) Notwithstanding subdivision (c), the administrative appeal process established by the director for institutional providers at final settlements shall commence with an informal conference with the provider, a representative of the department and the hearing officer. The hearing officer, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. Nothing in this subdivision shall prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (c).

"(g) Notwithstanding subdivision (c), the administrative appeal process established by the director for noninstitutional providers shall commence with an informal conference with the provider, a representative of the department, and the hearing officer. The informal conference shall be conducted no later than 90 days after the filing of a timely and specific statement of disputed issues by the noninstitutional provider. The administrative law judge, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. The review conducted at this informal level shall be completed no later than 180 days after the filing of a timely and specific statement of disputed issues by the noninstitutional provider. Nothing in this subdivision shall prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (c). For noninstitutional providers, the impartial hearing shall be conducted no later than 360 days after the issuance of the first statement of account status or demand for payment to the noninstitutional provider. A proposed decision shall be prepared within 60 days after the impartial hearing is concluded, and a final decision shall be adopted within 180 days of the hearing."

Cross References

Office of administrative hearings, see Government Code § 11370 et seq.
Review of administrative orders or decisions, see Code of Civil Procedure § 1094.5.

Code of Regulations References

Provider audit appeals, see 22 Cal. Code of Regs. 51016 et seq.

Library References

Social Security and Public Welfare ⇐241.105.
WESTLAW Topic No. 356A.

C.J.S. Social Security and Public Welfare § 135.

(d) After following this procedure, a provider who is not satisfied with the decision by the designated county department may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later than one year after receiving notice of the decision.

NOTE: Authority cited: Section 14132.95, Welfare and Institutions Code; Section 8, Chapter 939, Statutes of 1992; Section 3, Chapter 7, Statutes of 1993. Reference: Section 14132.95, Welfare and Institutions Code; Section 1396d(a)(7) of Title 42 of the United States Code; Article 7 (commencing with Section 12300) of Part 3 of Division 9 of the Welfare and Institutions Code; Section 440.170(f) of Title 42 of the Code of Federal Regulations.

HISTORY

1. New section filed 4-14-93 as an emergency; operative 4-14-93. Submitted to OAL for printing only pursuant to section 8, AB 1773 (Chapter 939, Statutes of 1992) (Register 93, No. 16).

Article 1.5. Provider Audit Appeals

§ 51016. Definitions.

(a) The following definitions shall be used throughout this article unless otherwise noted.

(1) Audits or Examination Report. "Audit or examination report" means a document that presents the final audit or examination findings and is formally issued to the provider by the Department upon the completion of the audit or examination.

(2) Completed Audit or Examination. "Completed audit or examination" means an audit or examination for which an audit or examination report has been issued.

(3) "Date of mailing" means the date postmarked on the envelope if postage was prepaid and the envelope was properly addressed.

(4) Demand for Repayment. "Demand for repayment" means a written notice issued to the provider by the Department that identifies the amount of the overpayment, determined by an audit or examination, that must be repaid. The notice may be made through the issuance of a statement of accountability, statement of account status, letter, or any combination of the foregoing.

(5) Duplicate. "Duplicate" means a counterpart or facsimile copy of the original produced by the same impression or from the same matrix as the original or by some technique of accurate reproduction.

(6) "Exit conference" means an informal meeting, between the provider and those Department representatives responsible for the audit or examination, at which the preliminary findings of the audit or examination are discussed.

(7) Formal Hearing. "Formal hearing" means an administrative hearing conducted by a hearing officer pursuant to Section 14171(b), Welfare and Institutions Code, and the provisions of this article.

(8) Hearing Auditor. "Hearing auditor" means an individual designated to conduct the informal level of review.

(9) Hearing Officer. "Hearing officer" means a hearing officer appointed by the Director pursuant to Section 14171(b), Welfare and Institutions Code.

(10) Informal Conference. "Informal conference" means a proceeding conducted in person or by telephone, for the purpose of scheduling the informal level of review and formal hearing; exchanging documents; and resolving other preliminary matters.

(11) Informal Level of Review. "Informal level of review" means an informal hearing for institutional providers and a pretrial conference for non-institutional providers, held by a hearing officer or hearing auditor prior to a formal hearing to clarify or resolve facts and issues in dispute.

(12) Party. "Party" means the provider, the Department, and any person, other than a hearing officer, allowed to appear in the proceedings.

(13) Institutional Provider. "Institutional provider" means any of the following:

(A) Any individual, entity or organization of a type required to be licensed pursuant to either Chapter 1 (commencing with Section 1200) or Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code, or exempt from licensure pursuant to Section 1206(b) through (l) Health and Safety Code, or Section 1254 Health and Safety Code which provides services or supplies under the Medi-Cal program, and is subject to audit by the Department.

(B) Any individual, entity, or organization of a type required to file a cost report or cost information with the Department.

(14) Non-institutional Provider. "Non-institutional provider" means any individual, entity, or organization other than those defined in subsection (13) who provides services or supplies under the Medi-Cal program, and who is subject to audit by the Department.

(15) File. "File" means delivery of a pleading or other paper to, and its date stamping by, the Office of Administrative Hearings and Appeals, Office of Legal Services, Department of Health Services.

(16) Serve. "Serve" means the delivery of a pleading or other paper on a party in the manner provided by Government Code Section 11505(c).

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Sections 14171 and 14172.5, Welfare and Institutions Code.

HISTORY

1. Repealer of Section 51016 and new Article 1.5 (Sections 51016–51043) filed 3–2–76; designated effective 4–1–76 (Register 76, No. 10). For prior history, see Register 72, No. 11, and Register 75, No. 23.
2. Repealer of Article 1.5 (Sections 51016–51043) and new Article 1.5 (Sections 51016–51047) filed 5–8–80; effective thirtieth day thereafter (Register 80, No. 19).
3. Amendment filed 10–11–84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).
4. Amendment filed 9–17–85; effective thirtieth day thereafter (Register 85, No. 38).

§ 51017. Provider Audit Hearing.

A provider may request a hearing under the provisions of this article to examine any disputed audit or examination finding which results in an adjustment to Medi-Cal program reimbursement or reimbursement rates by submitting a Statement of Disputed Issues to the Department in accordance with Section 51022.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Amendment filed 7–15–85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51018. Home Office—Chain Organization Related Entities.

The home office of a chain organization has no separate right to an individual hearing under this article. Where a provider in a chain organization disputes an audit or examination finding concerning the allocation of home office costs, other related entity costs or any other matter affecting all or some of the providers in the chain organization, all providers in the chain organization that are affected by the issue in dispute shall be made parties to the proceedings for the purpose of resolution of that issue only, in accordance with Section 51030.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51019. Amended Cost Reports.

(a) An amended cost report may be submitted by a provider and accepted by the Department for the fiscal period or periods for which proceedings are pending under this article.

(b) The hearing officer may suspend the proceedings until identification of any additional disputes that may result from an amended report filed by a provider.

(c) Additional issues which are raised by accepted cost report amendments may be included in the proceedings at the request of the provider in accordance with Section 51022.

(d) The hearing officer may dismiss the proceeding without prejudice to the right to request a subsequent hearing under this article when the hearing officer deems this course to be appropriate.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51020. Amended Audit Report.

(a) An amended audit report may be issued by or on behalf of the Department for the fiscal period or periods for which proceedings are pending under this article.

(b) The hearing officer may suspend the proceedings until identification of any additional disputes that may result from an amended audit report.

(c) Additional issues in dispute which are raised by the amended audit report may be included in the proceedings at the request of the provider in accordance with Section 51022.

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(d) The hearing officer may dismiss the proceeding without prejudice to the right to request a subsequent hearing under this article when the hearing officer deems this course to be appropriate.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51021. Exit Conference and Audit Report.

(a) The provider shall be afforded a reasonable opportunity to participate in an exit conference after the conclusion of any field audit or examination of records or reports of a provider, by or on behalf of the Department, and prior to the issuance of the Audit Report. The purpose of the exit conference is to:

(1) Inform the provider of the audit or examination findings and the supporting reasons and evidence.

(2) Inform the provider of the specific instances in which no records were found to substantiate claims billed to the program which was the subject of the audit or examination.

(3) Allow the provider an opportunity to present relevant information concerning the audit or examination findings.

(b) The provider must make available to the Department any records which were identified as unavailable for review or missing within 15 calendar days of the exit conference to be included in the Audit Report.

(c) Where the audit or examination involves the records or reports of a provider of pharmaceutical services:

(1) The auditor or reviewer shall identify missing prescriptions by beneficiary name, beneficiary number, prescription number and date of service to the provider at the exit conference.

(2) The audit worksheets relating to exceptions taken shall be furnished to the provider subsequent to the submission of missing prescriptions pursuant to subsection (b), in the event that a request for repayment of an overpayment is made.

(d) An audit or examination findings issued by or on behalf of the Department shall include the following:

(1) A complete copy of the audit report which identifies all items to which exception has been taken, the monetary value of each and the reason for the exception, including citation to the appropriate statutory or regulatory authority.

(2) Notice of the provider's right to a hearing pursuant to the provisions of this article. A copy of the provisions of this article shall accompany such notice.

NOTE: Authority cited: Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14170 and 14171, Welfare and Institutions Code.

History

1. Editorial correction of NOTE filed 12-14-84 (Register 84, No. 50).

§ 51022. Request for Hearing.

(a) An Institutional provider may request a hearing for any disputed audit or examination finding as follows:

(1) A written request shall be filed with the Department within 60 calendar days of the receipt of the written notice of the audit or examination findings.

(2) This request may be amended at any time during the 60 calendar day period.

(b) A Non-institutional provider may request a hearing on any disputed audit or examination finding as follows:

(1) A written request shall be filed with the Department within 30 calendar days of the receipt of the audit or examination finding.

(2) This request may be amended at any time during the 30 calendar day period.

(c) All late requests by either Institutional or Non-institutional providers shall be denied and the audit or examination findings deemed final unless the provider establishes in writing good cause for late filing within 15 calendar days of being notified of the untimeliness of its request.

(d) The request shall be known as "Statement of Disputed Issues." It shall be in writing, signed by the provider or the authorized agent, and shall state the address of the provider and of the agent, if any agent has been designated. A provider or the agent shall specify the name and address of the individual authorized on behalf of the provider to receive any and all documents, including the final decision of the Director, relating to proceedings conducted pursuant to this article. The Statement of Disputed Issues need not be formal, but it shall be specific as to each issue as are in dispute, setting forth the provider's contentions as to those issues and the estimated amount each issue involves. The information specified in subsection (e) shall also be included. If the hearing officer determines that a Statement of Disputed Issues fails to state the specific grounds upon which objection to the specific item is based, the provider or the agent shall be notified that it does not comply with the requirement of this regulation, and the reasons therefor.

(1) An Institutional provider shall be granted 30 calendar days after the date of the mailing of the notice of deficiency to the provider within which to file an amended Statement of Disputed Issues.

(2) A Non-institutional provider shall be granted 15 calendar days after the date of mailing of the notice of deficiency within which to file an amended Statement of Disputed Issues.

(3) If within the time permitted in (1) or (2) above, the Institutional or Non-institutional provider, respectively, or the agent fails to amend its appeal as notified, the appeal as to those issues shall be rejected.

(e) The request shall also specify whether the provider does or does not wish that an informal level of review among the parties be held, together with the reasons therefor. Either party may request, or the hearing officer may order, that a telephone conference call be initiated among the parties for discussion of the advisability of conducting an informal level of review. The hearing officer shall decide whether an informal level of review would be appropriate and notify the parties of this decision in writing.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).
2. Editorial correction of Authority cite (Register 95, No. 45).

§ 51023. Informal Level of Review.

(a) If the hearing officer determines that an informal level of review is appropriate, it shall be ordered and scheduled as soon as reasonably possible. The hearing officer, or a hearing auditor designated by the hearing officer, shall preside at this informal level of review.

(b) Written notice of the time and place of informal level of review shall be mailed to each party at least 30 calendar days before the date of the informal level of review. This period may be shortened with the consent of the parties. Any party may waive notice. This notice may be combined with the notice of formal hearing.

(c) Efforts shall be made to resolve the facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. Matters in dispute, raised in the provider's Statement of Disputed Issues pursuant to Section 51022, which are not discussed or raised at the informal level of review shall not be deemed waived.

(d) The proceedings at the informal level of review shall be electronically recorded unless the parties agree otherwise.

(e) The results of the informal level of review shall be:

(1) Served on the parties, within a reasonable time, in the form of a written Report of Findings or Pretrial Order.

(2) For Institutional providers, the report of findings shall be considered as final unless the provider submits written request for a formal hearing in accordance with Section 51024.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).
2. Amendment of subsection (c) filed 7-13-95; effective thirtieth day thereafter (Register 95, No. 29).

§ 51024. Request for Formal Hearing.

(a) The form and content of the request shall be as specified in Section 51022(d).

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this paragraph shall apply only to those overpayments determined by audit reports issued after April 6, 1976 and before June 28, 1981. In all other cases, interest shall be paid in accordance with the provisions of Sections 14171(e) and 14172.5, Welfare and Institutions Code.

(f) As used in this section, "Statement of Account Status" also includes statement of accountability or demand for repayment.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Sections 14171, 14171.5 and 14172.5, Welfare and Institutions Code.

HISTORY

1. Amendment filed 9-15-82 as an emergency; effective upon filing (Register 82, No. 38). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1-13-83.
2. Certificate of Compliance transmitted to OAL 1-13-83 and filed 2-16-83 (Register 83, No. 8).
3. Editorial correction of NOTE filed 12-13-84 (Register 84, No. 50).
4. Amendment filed 9-17-85; effective thirtieth day thereafter (Register 85, No. 38).
5. Editorial correction of subsection (f) (Register 95, No. 45).

§ 51048. Administrative Review of Performance Under Selective Provider Contracts.

(a) As an alternative to judicial review pursuant to Welfare and Institutions Code Section 14087.27(a), administrative review of disputes between a contracting hospital and the state relating to performance under the Selective Provider Contracting Program shall be heard by an independent hearing examiner appointed by the Director of the Department of Health Services.

(b) The independent hearing examiner shall conduct an administrative hearing and render a proposed decision to be adopted by the Director pursuant to the applicable procedural requirements of Article 1.5, Provider Audit Appeals (Sections 51016-51047) with the following exceptions:

(1) There shall be no exit conference or informal hearings.

(2) All references to a hearing officer shall apply to the independent hearing examiner appointed by the Director pursuant to Welfare and Institutions Code Section 14087.27.

NOTE: Authority cited: Sections 14124.5 and 14082, Welfare and Institutions Code; Section 57, Chapter 328, Statutes of 1982; and Chapter 1594, Statutes of 1982. Reference: Section 14087.27, Welfare and Institutions Code.

HISTORY

1. New section filed 10-8-82 as an emergency; effective upon filing (Register 82, No. 41). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3-5-83.
2. Certificate of Compliance transmitted to OAL 12-31-82 and withdrawn 1-28-83 (Register 83, No. 12).
3. New section refiled 1-28-83 as an emergency; effective upon filing (Register 83, No. 12). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5-28-83.
4. Certificate of Compliance transmitted to OAL 5-26-83 and filed 6-30-83 (Register 83, No. 27).
5. Editorial correction of subsection (b) (Register 95, No. 45).

Article 1.6. Skilled Nursing Facility and Intermediate Care Facility Certification Appeals Procedure

§ 51048.1. Limitations.

(a) A skilled nursing and/or intermediate care facility Medi-Cal provider may, in accordance with the regulations contained in Sections 51048.2 through 51048.8, appeal the decision of the Department that a facility is not qualified to participate in the Medi-Cal program.

(b) The Department in rendering its determination shall set forth the pertinent facts and conclusions upon which the determination is made, and shall notify the provider of its right to appeal under subdivision (a).

(c) The effective date of a determination rendered under this article is as follows:

(1) A determination not to renew a certification is effective on the date the existing certification actually expires.

(2) A determination to deny a certification is effective upon the receipt of the determination by the provider, except if the provider files a request for reconsideration under Section 51048.3, the determination shall be effective upon receipt of the reconsidered determination by the provider.

(d) These appeal processes are only available to Medi-Cal providers of skilled nursing facilities who do not participate in the Medicare program. Providers who participate in both Medi-Cal and Medicare may appeal certification decisions to the Department of Health and Human Services in accordance with 42 CFR, 405.1501 et seq. A final decision rendered pursuant to 42 CFR 405.1501 et seq. is binding for purposes of Medi-Cal participation.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Section 14100.1, Welfare and Institutions Code.

HISTORY

1. New Article 1.6 (Sections 51048.1-51048.8) filed 7-31-85; effective thirtieth day thereafter (Register 85, No. 31).

§ 51048.2. Right to a Reconsideration.

(a) A skilled nursing and/or intermediate care facility provider who disagrees with a determination that the skilled nursing or intermediate care facility does not qualify as a provider of services in the Medi-Cal program may, in accordance with Section 51048.3, request that the Department reconsider that decision.

(b) The reconsideration of a nonrenewal of an existing provider agreement shall be completed prior to the end of the certification period.

(c) The reconsideration of a denial of an initial application for certification shall be made within 30 days of the receipt of the request for a reconsideration.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Section 14100.1, Welfare and Institutions Code.

HISTORY

1. Editorial correction of subsection (a) (Register 95, No. 45).

§ 51048.3. Request for Reconsideration.

(a) If a provider or authorized representative of the provider requests a reconsideration, the request shall be filed within 15 days after the date of receipt of notice of the determination that the provider does not qualify as a Medi-Cal provider. The request shall be filed with the Director of the Department of Health Services or the designee authorized to accept such requests.

(b) A request for reconsideration shall:

(1) Be in writing.

(2) State the reasons upon which the provider disagrees with the determination.

(3) Include relevant evidence.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Section 14100.1, Welfare and Institutions Code.

§ 51048.4. Reconsidered Determination.

(a) The Department shall review each request for reconsideration that is filed in accordance with Section 51048.2. The Department shall reconsider the determination and the reasons on which it was based. The Department shall issue, within 30 days of the receipt of the request, a reconsidered determination affirming, revising, in whole or in part, or reversing the determination.

(b) The reconsidered determination shall be based upon the evidence considered in making the original determination and any other evidence submitted by the provider and verified by the Department.

(c) The written reconsidered determination shall be mailed to the provider or his authorized representative. The reconsidered determination shall:

(1) Contain the reason or reasons for affirming, revising or reversing the determination.

(2) Inform the provider of the right to a full evidentiary hearing.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Section 14100.1, Welfare and Institutions Code.

§ 51048.5. Right to Full Evidentiary Hearing.

(a) A skilled nursing facility or intermediate care facility provider which disagrees with the Department's reconsidered determination that the skilled nursing facility or intermediate care facility does not qualify as a provider of services in the Medi-Cal program may, by complying with Section 51048.6 request a full evidentiary hearing on the provider

(b) A party may request the disqualification of a hearing officer by filing an affidavit stating in detail the grounds upon which it is claimed that a fair and impartial hearing cannot be given or that the hearing officer has an interest in the proceeding. The hearing officer shall immediately present the affidavit to the Chief Counsel of the Department who shall:

(1) Investigate the allegations and advise the complaining party in writing of the decision granting or denying the request to disqualify the hearing officer. A copy of the decision shall be mailed to the other parties. Or

(2) Reassign the case to another hearing officer without investigation.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment of subsection (b)(1) filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51044. Decision.

(a) The hearing officer shall take the matter under submission at the conclusion of the hearing. A proposed decision, in a form that may be adopted as the decision of the Director, shall be submitted to the Director as soon as practical. A copy of the proposed decision, upon submission to the Director, shall be:

(1) Filed by the Department as a public record.

(2) Served by the Department on each party in the case and each party's representative.

(b) The Director may:

(1) Adopt the proposed decision without reading or hearing the record.

(2) Reject the proposed decision and have a decision prepared based upon the documentary and electronically recorded record, with or without taking additional evidence. The Director shall decide no case provided for in this paragraph without affording the parties the opportunity to present either oral or written argument.

(3) Refer the matter to the hearing officer to take additional evidence. If the case is so assigned, the hearing officer shall prepare a proposed decision as provided in subsection (a), upon the additional evidence and the documentary and electronically recorded record of the prior hearing. A copy of such proposed decision shall be furnished to each party and each party's representative as prescribed in subsection (a).

(c) The decision shall be final upon adoption by the Director. Copies of the decision of the Director shall be mailed by certified mail to the designated representative of the provider.

(d) A dismissal may be issued if a provider fails to appear at a formal hearing. A copy of such dismissal shall be mailed to each party together with a statement of the provider's right to reopen the hearing.

(e) The Director may vacate any dismissal if the provider makes application in writing, within ten calendar days after personal service or receipt of such dismissal, showing good cause for failure to appear at the hearing. Lack of good cause shall be inferred if a continuance of the formal hearing is not requested promptly upon discovery of the reasons for failure to appear at the hearing.

(f) If a party to a formal hearing other than the provider fails to appear at a hearing and the hearing officer issues a decision on the merits adverse to that party's interests, the decision shall be accompanied by a statement of the party's right to make application to vacate the decision. The application may be in writing and shall be made within ten calendar days after personal service or mailing of the decision. Upon a showing of good cause for failure to appear at the hearing, the Director may issue an order to vacate the decision and the matter may be set for further hearing. Lack of good cause will be inferred when a continuance of the hearing was not requested promptly upon discovery of the reasons for failure to appear at the hearing.

(g) The parties shall be given written notice of an order granting or denying any application to vacate a decision.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51045. Reconsideration.

(a) The Department may order a reconsideration of all or part of the case on its own motion or on petition of any party. The power to order a reconsideration shall expire 30 calendar days after delivery or mailing of a decision to the provider. The Department may grant a stay of expiration of its power to order reconsideration:

(1) for up to 30 days for the purpose of enabling a party to file a petition for reconsideration; or

(2) for up to 10 days when needed solely for the purpose of considering a petition filed prior to expiration of its power to order reconsideration.

The petition of a party shall be deemed denied if the Department takes no action within the time allowed for ordering reconsideration.

(b) The case may be:

(1) Reconsidered by the Department on all the pertinent parts of the records and such additional evidence and arguments as may be permitted.

(2) Assigned to a hearing officer for further written or oral hearing.

(c) The decision for a reconsideration assigned to a hearing officer shall be subject to the procedure provided in section 51044.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Change without regulatory effect amending subsection (a) filed 10-4-90 pursuant to section 100, title 1, California Code of Regulations (Register, No. 45).

§ 51046. Judicial Review.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Repealer filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51047. Recovery of Overpayments.

(a) When it is established upon audit that an overpayment has been made to a provider, the Department shall begin liquidation of any overpayment to a provider 60 days after issuance of the first Statement of Accountability or demand for repayment. The demand for repayment or Statement of Accountability shall be issued no later than 60 days after the issuance of the audit or examination report establishing such overpayment. When a noninstitutional provider has filed a request for hearing pursuant to Section 51022 of this Article, liquidation of the disputed overpayments shall be deferred until the appeal is rejected or a final administrative decision is rendered. The overpayment shall be recovered by any of the following methods:

(1) Lump sum payment by the provider.

(2) Offset against current payments due to the provider.

(3) A repayment agreement executed between the provider and the Department.

(4) Any other method of recovery available to and deemed appropriate by the Director.

(b) An offset against current payments shall continue until one of the following occurs:

(1) The overpayment is recovered.

(2) The Department enters into an agreement with the provider for repayment of overpayment.

(3) The Department determines, as a result of proceedings under this article, that there is no overpayment.

(c) The provider shall pay interest at the rate of seven percent per annum on any unrecovered overpayment in all cases where the statement of account status was issued before June 28, 1981. In all other cases, the provider shall pay interest as provided by Welfare and Institutions Code Section 14171(f).

(d) Nothing in this section shall prohibit a provider from repaying all or a part of the disputed overpayment without prejudice to his right to a hearing under this article.

(e) Any recovered overpayment that is subsequently determined to have been erroneously collected shall be promptly refunded to the provider, together with interest computed at the legal rate of seven percent per annum from the date of such liquidation or 60 days after issuance of the audit or examination findings, whichever is later. The provisions of

(2) Hearsay evidence shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.

(3) The rules of privilege shall be effective to the same extent that they are now or hereafter may be recognized in civil actions and irrelevant and unduly repetitious evidence shall be excluded.

(f) The following additional exception to the "best evidence" rule (Evidence Code Section 1500) applies:

(1) A duplicate is admissible to the same extent as an original unless:

(A) A genuine question is raised as to the authenticity of the original or the duplicate.

(B) It would be unfair to admit the duplicate in lieu of the original.

(g) A hearing officer may question any party or witness and may admit any relevant and material evidence.

(h) The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts ad safeguard the rights of the parties. Prior to taking evidence, the hearing officer shall set forth the order in which evidence will be received.

(i) The Department shall present its audit findings and evidence first at the hearing. The Department has the burden of proof of demonstrating, by a preponderance of the evidence, that the audit findings were correctly made. Once the Department has presented such a prima facie case, the burden of proof shifts to the provider to demonstrate, by a preponderance of the evidence, that the provider's position regarding disputed issues is correct.

(j) The burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

(k) The hearing shall be conducted in the English language. The proponent of any testimony to be offered by a witness who does not speak the English language proficiently shall provide an interpreter, approved by ting officer, proficient in the English language and the language the witness will testify, to serve as interpreter during the hearing. st of the interpreter shall be paid by the party providing the interpreter.

NOTE Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51038. Official Notice.

(a) The hearing officer shall take official notice of those matters which must be judicially noticed by a court under Section 451 of the Evidence Code. The hearing officer may take official notice of those matters set forth in Section 452 of the Evidence Code.

(b) Parties present at the formal hearing shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto.

(c) Each party shall be given a reasonable opportunity on request to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing officer.

NOTE Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51039. Continued or Further Hearings.

(a) A hearing officer may continue a formal hearing to another time or place if deemed advisable or upon request and a showing of good cause.

(1) Written notice of the time and place of the continued formal hearing, except as provided herein, shall be in accordance with this article.

(2) Oral notice of the time and place of the continued formal hearing may be given to each party present at the formal hearing. Such oral notice shall be confirmed in writing by the hearing officer subsequent to the formal hearing.

(b) The hearing officer may order a further formal hearing prior to the decision, if the hearing officer deems advisable or on a showing of good cause. Notice shall be given in accordance with Section 51025.

NOTE Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51040. Evidence.

(a) In Non-institutional provider cases, notwithstanding any other provision of these regulations, and unless otherwise ordered by the assigned Administrative Law Judge, the parties shall:

(1) Not less than ten (10) calendar days prior to the pretrial conference, file a list of all documents and other items to be offered into evidence at the formal hearing, except for impeachment or rebuttal, with a brief statement following each document describing its substance or purpose and the identity of the sponsoring witness.

(2) Not less than seven (7) calendar days prior to the date on which the formal hearing is scheduled to commence, exchange copies of all documents and other items to be offered into evidence at the formal hearing other than for impeachment or rebuttal. Each proposed exhibit shall be premarked for identification.

(3) Prior to the commencement of the formal hearing, any party proposing to object to the receipt in evidence of any proposed exhibit shall advise the opposing party of such objection. The parties shall confer with respect to any objections in advance of the formal hearing and attempt to resolve them. Failure to comply with the requirements of (1) or (2) above shall constitute a ground for objection to the introduction of undisclosed documents and other items, into evidence other than for impeachment or rebuttal.

(b) In all cases, the hearing officer, in order to obtain additional evidence necessary for the proper determination of the case, may:

(1) Continue the formal hearing and hold the record open for either party to produce additional evidence.

(2) Close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any material submitted after the close of the formal hearing shall be made available to both parties and each party shall have the opportunity for rebuttal.

(3) Order a further formal hearing if the nature of the additional evidence or the refutation thereof makes a further hearing desirable.

NOTE Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).

§ 51041. Representation at a Formal Hearing.

(a) A hearing officer or hearing auditor may refuse to allow any person to represent a party in any hearing when the person:

(1) Engages in unethical, disruptive or contemptuous conduct.

(2) Intentionally fails to comply with the proper instructions or orders of the hearing officer or hearing auditor or the provisions of this article.

(b) This section shall not be construed to limit the right of a party or its representative to make evidentiary and procedural objections and state the reasons therefor.

NOTE Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment of subsection (a) filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51042. Oral Argument and Briefs.

(a) The hearing officer shall grant oral and may grant written argument at the request of any party made prior to the close of the formal hearing. The parties shall be advised as to the time and manner within which written argument is to be filed.

(b) The hearing officer may require any party to submit written memoranda pertaining to any or all issues raised in the formal hearing.

NOTE Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51043. Disqualification of Hearing Officer.

(a) A hearing officer shall voluntarily withdraw from any proceedings in which the hearing officer:

(1) Cannot give a fair or impartial hearing.

(2) Has an interest

(b) A party shall have the same rights as are accorded a party under the provisions of Section 11507.7 of the Government Code in the event that a request for discovery pursuant to this section has not been granted. In the event an order to show cause is issued, a copy shall be filed with each party.

(c) The provisions of this article provide the exclusive right to and method of discovery as to any proceeding governed by this article.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment of subsection (a) filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51033. Subpoenas and Witnesses.

(a) The hearing officer shall issue subpoenas and subpoenas duces tecum before the formal hearing, for attendance or production of documents at the formal hearing, as necessary or at the request of any party. The hearing officer may also issue subpoenas and subpoenas duces tecum after the formal hearing has commenced. Compliance with the provisions of Section 1985, California Code of Civil Procedure, shall be a condition precedent to the issuance of a subpoena duces tecum.

(b) The process issued pursuant to subsection (a) shall be extended to all parts of the State and shall be served in accordance with the provisions of Sections 1987 and 1988, California Code of Civil Procedure. No witness shall be obliged to attend at a place out of the county in which he resides unless the distance be less than 150 miles from his place of residence except that the hearing officer, upon affidavit of any party showing that the testimony of such witness is material and necessary, may endorse on the subpoena an order requiring the attendance of such witness.

(c) All witnesses appearing pursuant to subpoena, other than the parties or officers or employees of the State or any political subdivision thereof, shall receive fees and all witnesses appearing pursuant to subpoena, except the parties, shall receive mileage in the same amount and under the same circumstances as prescribed by law for witnesses in civil actions in a superior court.

(d) Witnesses appearing pursuant to subpoena, except the parties, who attend formal hearings at points so far removed from their residences as to prohibit return thereto from day to day shall be entitled, in addition to fees and mileage, to a per diem compensation of $3.00 for expenses of subsistence for each day of actual attendance and for each day necessarily occupied in traveling to and from the hearing. Fees, mileage and expenses of subsistence shall be paid by the party at whose request the witness is subpoenaed.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51034. Depositions.

(a) On verified petition of any party, the hearing officer may order that the testimony of any material witness residing within or without the State be taken by deposition in the manner prescribed by law for depositions in civil actions. The petition shall set forth:

(1) The nature of the pending proceeding.

(2) The name and address of the witness whose testimony is desired.

(3) A showing of the materiality of his testimony.

(4) A showing that the witness will be unable or cannot be compelled to attend.

(5) A request for an order requiring the witness to appear and testify before an officer named in the petition for that purpose.

(b) The hearing officer's order for taking of testimony by deposition from a witness residing out-of-State shall be supported by a court order. The court order shall be obtained by filing a petition in the Superior Court of Sacramento County, in accordance with Section 11189, Government Code.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51036. Affidavits.

(a) Any party may mail or deliver to the opposing party, at least ten calendar days prior to a formal hearing or a continued hearing, a copy of any affidavit to be introduced in evidence, together with a notice as provided in subsection (b). Unless the opposing party, within seven days after such mailing or delivery, mails or delivers to the proponent a request to cross-examine an affiant, the right to cross-examine such affiant is waived and the affidavit, if introduced in evidence, shall be given the same effect as if the affiant had testified orally. If an opportunity to cross-examine an affiant is not offered after request therefor is made as herein provided, the affidavit may be introduced in evidence, but shall be given only the same effect as other hearsay evidence.

(b) The notice referred to in subsection (a) shall be substantially in the following form:

NOTICE

The accompanying affidavit of (here insert name of affiant) will be introduced as evidence at the formal hearing in (here insert title of proceeding). (Here insert name of affiant) will not be called to testify orally and you will not be entitled to question him unless you notify (here insert name of proponent or his attorney) at (here insert address) that you wish to cross-examine him. To be effective your request must be mailed or delivered to (here insert name of proponent or his attorney) on or before (here insert a date seven days after the day of mailing or delivering the affidavit to the opposing party).

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51036. Preparation for Formal Hearing.

A party appearing at a formal hearing shall have necessary evidence and witnesses present and be ready to proceed. Each party shall make available sufficient copies, as indicated by the hearing officer, of any documents to be introduced in evidence. The hearing officer, if necessary and following reasonable notice, may require any or all parties to submit a written statement of contentions and reasons, together with any requested documents. Each party submitting written statements and documents shall also provide a copy to all other parties.

NOTE: Authority cited: Sections 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).
2. Editorial correction of Authority cite (Register 95, No. 45).

§ 51037. Conduct of Formal Hearing.

(a) Testimony shall be taken only on oath, affirmation or penalty of perjury.

(b) The proceedings at the formal hearing shall be electronically recorded.

(c) Each party shall have the right to:

(1) Call and examine parties and witnesses.

(2) Introduce exhibits.

(3) Question opposing witnesses and parties on any matter relevant to the issues even though the matter was not covered in the direct examination.

(4) Impeach any witness regardless of which party first called the witness to testify.

(5) Rebut the evidence against him.

(d) The provider shall not be called to testify during presentation of the Department's prima facie case pursuant to subsection (i). A provider who thereafter fails to testify, in the provider's behalf, may be called and examined by the Department as if under examination.

(e) The formal hearing need not be conducted according to technical rules relating to evidence and witnesses.

(f) Relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions.

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(b) An institutional provider shall have 30 calendar days following the receipt of the written Report of Findings within which to file a request for formal hearing with the Director. The request shall be deemed filed on the date mailed to the Department. The audit findings, as amended by the Report of Findings, shall be considered final and deemed dispositive of all issues raised in the Statement of Disputed Issues filed pursuant to Section 51022 at the end of this period unless good cause for late filing is found.

(c) A request for formal hearing filed after the time permitted in subsection (b) shall be rejected unless the provider establishes in writing good cause for late filing within 15 calendar days of being notified of the untimeliness of its request.

(d) A formal hearing shall routinely be scheduled in each case involving a Non-institutional provider. No separate request for formal hearing shall be required.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).

§ 51025. Notice of Formal Hearing.

Written notice of the time and place of formal hearing shall be mailed to each party at least 30 calendar days before the date of hearing. This period may be shortened with the consent of the parties. Any party may waive notice.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51026. Department Mailings.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

...ber filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51027. Time and Place of Informal Level of Review and Formal Hearing.

(a) The hearing officer shall determine the time and place of an informal level of review or formal hearing. The informal level of review or formal hearing shall be held at one of the following locations.

(1) In the County of:

(A) San Francisco if the provider resides within the First Appellate District.

(B) Los Angeles if the provider resides within the Second or Fourth Appellate District.

(C) Sacramento if the provider resides within the Third or Fifth Appellate District.

(b) Notwithstanding subdivision (a), the hearing officer may select:

(1) A different place nearer the place where the provider resides.

(2) Any place within the State agreeable to the parties.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Amendment filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51028. Merger of Successive Requests for Hearings.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Repealer filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51029. Consolidation of Proceedings.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Repealer filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51030. Hearing Officer's Authority.

(a) The hearing officer may, on his/her own motion or the motion of any party, as the hearing officer deems appropriate:

(1) Consolidate for hearing or decision any number of issues or appeals when the facts and circumstances are similar and no substantial right of any party will be prejudiced.

(2) Join other parties, grant continuances and hold additional formal hearings as necessary to dispose of all issues.

(3) Hear any issue before any other issue in the proceeding where it is found that the decision on that issue could abate further proceedings.

(4) Prepare a proposed decision on any separately heard issue for the Director's signature and postpone hearing on any remaining issues until a final decision has been issued by the Director.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Repealer and new section filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51031. Severance of Issues.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Repealer filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51032. Discovery.

(a) After the acceptance of the Statement of Disputed Issues, a party, upon written request made to another party, prior to the hearing and within thirty (30) calendar days after receipt of the Notice of Acceptance of the Statement of Disputed Issues or within fifteen (15) calendar days after the receipt of the Notice of Acceptance of an amended Statement of Disputed Issues or issuance of a Report of Findings, is entitled to:

(1) Obtain the names and addresses of witnesses to the extent known to the other party, including, but not limited to, those intended to be called to testify at the informal hearing or formal hearing.

(2) Inspect and make a copy of any of the following in the possession or custody or under the control of the other party:

(A) Statements pertaining to the subject matter of the proceeding made by any party to another party or person.

(B) Statements of witnesses then proposed to be called by the party and of other persons having personal knowledge of the acts, omissions or events which are the basis for disputed audit or examination findings, not included in subdivision (2)(A).

(C) All writings, including but not limited to audit work papers, patient ledgers, medical records and invoices or things which the party then proposes to offer into evidence.

(D) Other writing or thing which is relevant and which would be admissible in evidence.

(E) Investigative reports made for or on behalf of the Department or other party pertaining to the subject matter of the proceeding, to the extent that such reports:

(1) Contain the names and addresses of witnesses or of persons having personal knowledge of the acts, omissions or events which are the basis for the disputed audit or examination findings.

(2) Reflect matters perceived by the investigator in the course of his investigation.

(3) Contain or include by attachment any statement or writing described in subsections (2)(A) through (2)(D) inclusive, or summary thereof.

(4) For the purpose of this section, "statements" includes written statements by the person, signed or otherwise authenticated by the person, stenographic, mechanical, electrical or other recordings, or transcripts thereof, or oral statements by the person and written reports or summaries of such oral statements.

(5) Nothing in this section shall authorize the inspection or copying of any writing or thing which is privileged from disclosure by law or otherwise made confidential or protected as the attorney's work product.

(6) Any denial of discovery by a party shall be in writing and shall be accompanied by a written statement describing the specific reasons for denial as to each item of discovery denied. Such a denial shall be mailed within 30 calendar days from the date of filing the request for discovery.

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