FINAL STATEMENT OF REASONS

Welfare and Institutions (W&I) Code Section 14105 requires the Department of Health Care Services (Department) to adopt regulations establishing reimbursement rates for Medi-Cal providers of health care services and mandates for the emergency adoption of regulations for these changes in response to legislative budgeting decisions.

This emergency regulatory action amends the California Code of Regulations (CCR), Title 22 to reflect reimbursement rates established by the Department for specific types of facilities providing long-term care services to Medi-Cal beneficiaries. There are two time periods affecting the CCR sections established in the table that are revealed through this regulatory action. The first time period being July 1, 2003 through July 31, 2003, which reflects the standard reimbursement rate for that period in addition to the Quality Assurance Fee (QAF), as described below. The second time period is the rate year August 1, 2003 through July 31, 2004. In the 2003-04 Budget Act (Chapter 157, Statutes of 2003), Items 4260-101-0001 and 4260-101-0890, the Legislature appropriated funding to pay these rates. These reimbursement rates are for services provided on or after August 1, 2003 and include the QAF, as described below.

This regulatory action establishes that reimbursement rates, as described above, include the QAF, pursuant to provisions under Health and Safety (H&S) Code, Sections 1324 through 1324.14. These provisions require the Department to impose a QAF of six percent of the entire gross receipts for each Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H), and Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N), effective July 1, 2003.

The Title 22, CCR sections that are affected through this regulatory action, the service and the weighted average percentage change are specified in the table below.

Section 51510(e)
Service Nursing Facility Level A Services
Weighted Average Percentage Change 1.47

Section 51510.1(d) & (e)
Service Intermediate Care Services for the Developmentally Disabled
Weighted Average Percentage Change 2.38

Section 51510.2(a)
Service Intermediate Care Services for the Developmentally Disabled-Habilitative
Weighted Average Percentage Change 0.00

Section 51510.3(a)
Service Intermediate Care Services for the Developmentally Disabled-Nursing
Weighted Average Percentage Change 0.00

Section 51511(a)
Service Nursing Facility Level B Services 2003-04
Weighted Average Percentage Change 3.92

Section 51511.5(a), (e) (f) & (g)
Service Nursing Facility Services – Subacute Care Reimbursement
Weighted Average Percentage Change 0.82

Section 51511.6(a), (b) & (c)
Service Nursing Facility Services – Pediatric Subacute Care Reimbursement
Weighted Average Percentage Change 2.00

Section 51535(d)
Service Leave of Absence
Weighted Average Percentage Change 2.02

Section 51535.1(d)
Service Bed Hold for Acute Hospitalization
Weighted Average Percentage Change 2.02

Section 51544(h)
Service Hospice Care
Weighted Average Percentage Change N/A

Section 54501(b)
Service Adult Day Health Care Services
Weighted Average Percentage Change 1.47

The percentages listed above cannot be used to determine the rate for each facility category from the prior year. The percentage changes shown above are averages of all facility categories in each regulation section, weighted by patient days for those categories.

Changes to the following sections of CCR, Title 22, are as follows:

Section 51510(e)(1)
Service Nursing Facility Level A Services
Description Amends rates to reflect updated facility cost data. Deletes the two categories based on number of beds or bed size and establishes one rate for all facilities irrespective of the number of beds.

Section 51510(e)(2)
Service Nursing Facility Level A Services
Description Adopts a new paragraph (2) that establishes rates based on peer groupings by geographical location and sets a specific rate for facilities with 100 or more beds.

Section 51510(e)(3)
Service Nursing Facility Level A Services
Description Moves the content of paragraph (2) to paragraph (3) and amends the language for clarity and parallel construction.

Section 51510(e)(4)
Service Nursing Facility Level A Services
Description Moves the content of paragraph (3) to paragraph (4) and amends the language for clarity and parallel construction.

Section 51510.1(d)
Service Intermediate Care Services for the Developmentally Disabled
Description Amends rates to reflect updated facility cost data and the QAF. Adds reference to H&S Code Section 1324.2 for the QAF program, implemented 7/1/03. The amended rates effective 7/1/03 reflect rates initially established in 8/1/02 plus the QAF. The 8/1/03 rates reflect the updated facility costs plus the QAF. This subsection also includes non-substantial language changes for clarity and sentence structure and a non-substantial capitalization change under paragraph (1).

Section 51510.1(e)
Service Intermediate Care Services for the Developmentally Disabled
Description Removes existing language because it is no longer relevant to Section 51510.1 because the Department is no longer involved in determining the cost-based reimbursement for these facilities. Adopts new language to clarify that the rate year established under this section is August 1st through July 31st per the 2003-04 Budget Act.

Section 51510.2(a)
Service Intermediate Care Services for the Developmentally Disabled-Habilitative
Description Amends rates to reflect updated facility cost data and the QAF. Adds reference to H&S Code Section 1324.2 for the QAF program, implemented 7/1/03. The amended rates effective 7/1/03 reflect rates initially established in 8/1/02 plus the QAF. The 8/1/03 rates reflect the updated facility costs plus the QAF.

Section 51510.3(a)
Service Intermediate Care Facilities for the Developmentally Disabled – Nursing
Description Amends rates to reflect updated facility cost data and the QAF. Adds reference to H&S Code Section 1324.2 for the QAF program, implemented 7/1/03. The amended rates effective 7/1/03 reflect rates initially established in 8/1/02 plus the QAF. The 8/1/03 rates reflect the updated facility costs plus the QAF.

Section 51511(a)(1)
Service Nursing Facility Level B Services
Description Amends rates for both bed size categories to reflect updated facility cost data and updates the dates to reflect the fiscal year 2003-04 rate setting period.

Section 51511(a)(2)
Service Nursing Facility Level B Services
Description Amends the rates for nursing facilities that are distinct parts of acute care hospitals. Also amends dates and the audit disallowance factor to reflect data used for the fiscal year 2003-04 rate setting. Includes a non-substantial change under paragraph (F) adding a missing “s”.

Section 51511(a)(4)
Service Nursing Facility Level B Services
Description Amends designated swing bed facilities rates.

Section 51511(a)(6)
Service Nursing Facility Level B Services
Description Includes a non-substantial change to correct an existing inaccurate cross reference.

Section 51511.5(a)
Service Nursing Facility Services-Subacute Care Reimbursement
Description Updates the dates to reflect the fiscal year 2003-04 rate setting period. Conforms the regulatory language to the approved Medicaid State Plan Attachment 4.19-D. Amends the rates to reflect updated facility cost data.

Section 51511.5(e) & (f)
Service Nursing Facility Services – Subacute Care Reimbursement
Description Updates the dates to reflect the fiscal year 2003-04 rate setting period and amends the audit disallowance factor. Includes a non-substantial change to spell out the acronym “DP/NF” for clarity.

Section 51511.5(g)
Service Nursing Facility Services – Subacute Care Reimbursement
Description Specifies a non-substantial change to correct an existing inaccurate cross reference.

Section 51511.6(a), (b), & (c)
Service Nursing Facility Services – Pediatric Subacute Care Reimbursement
Description Amends rates based on a model which estimates expected costs. (Refer to last paragraph under heading below: Annual Long-Term Care Reimbursement Methodology)

Section 51535(d)
Service Leave of Absence
Description Amends the rate based on the Consumer Price Index (CPI) applicable for the 2003-04 rate period.

Section 51535.1(d)
Service Bed Hold for Acute Hospitalization
Description Amends the rate based on the CPI applicable for the 2003-04 rate period.

Section 51544(h)
Service Hospice Care
Description Implements the Centers for Medicare & Medicaid Services (CMS) allowable reimbursement rate for hospice care and removes existing language that is no longer accurate.

Section 54501(b)
Service Adult Day Health Care Services
Description Amends rates to reflect updated facility cost data.

EXPLANATION OF CHANGES AND DATES

1. Reimbursement Rates

(a) The reimbursement rates are updated to reflect data from each facility's annual or fiscal period closing cost report (except for Pediatric Subacute Care facilities where updated rates are based on a model). Reported costs are adjusted based on audits of reported costs performed by the Department's Audits and Investigations Program, Financial Audits Branch. These rates represent the maximum amount paid for services

(b) In Sections 51510(e)(1) & (2)

Effective August 2, 2003, Level A Free Standing Nursing Facility's, regardless of the number of beds, would have rates set depending on the facility's geographical location using the methodology currently applicable to Los Angeles, Bay Area or all other counties. Facilities with licensed bed capacities with 100+ bedsize who received a rate of $89.54 effective August 1, 2002, will continue to receive a reimbursement of at least
$89.54 until such time their prospective county rate exceeds the $89.54 reimbursement rate. When the prospective county rate exceeds the $89.54 reimbursement rate, facilities with licensed bed capacities with 100+ bedsize will receive the higher rate.

(c) In Section 51544(h)

Initially the Hospice room and board reimbursement rate was set at 95 percent of the weighted rate for nursing facilities Level A and nursing facilities Level B. The rate should have been set at the CMS reimbursement rate of 95 percent of the facility's Medi-Cal per diem rate where the individual resides. However, due to the Department's fiscal intermediary, Electronic Data System (EDS), not being able to accommodate the 95 percent Medi-Cal per diem, the Department negotiated with Hospice providers to reimburse at 95 percent of the weighted rate. EDS has since

updated their systems to accommodate billing at 95 percent of the facility's Medi-Cal per diem rate where the Hospice patient resides. The rates listed in Subsection (h)(1) are no longer applicable and therefore removed and the applicable rate in Subsection (h)(2) has been moved directly under (h) for organizational clarity.

2. Audit Disallowance Factor and Dates

In Sections 51511(a)(2)(C) and 51511.5(f)(2), the audit disallowance factor and dates are updated to reflect the fiscal year 2003-04 rate setting period. The audit disallowance factor is based on audits of a random sample of facilities, reflects costs that are found not to be allowable costs under the Medi-Cal program, and is applied to all facilities in that regulation section.

ANNUAL LONG-TERM CARE REIMBURSEMENT METHODOLOGY

Welfare and Institutions Code Section 14126.25 requires that the Department establish reimbursement rates for long-term care facilities by August 1st of each year. These rates are established on the basis of cost data submitted by facilities as defined under the Department's California State Plan.

The Department's reimbursement methodology for long-term care facilities provides for a prospective flat-rate system with long-term care facilities divided into peer groups by licensure status, level of care, geographic area, and/or bedsize. Rates for each category (except Pediatric Subacute, as explained below) are determined based on data obtained from each facility's annual or fiscal period closing cost report. All reported costs are adjusted based on audits of reported costs performed by the Department's Audits and Investigations Program, Financial Audits Branch. For ICF/DD, Freestanding Nursing Facilities Level A, Distinct Part Nursing Facilities and Subacute Facilities, each facility is audited. For Freestanding Nursing Facilities Level B, ICF/DD-H and ICF/DD-N, a sample from each peer group is audited and the combined results of these audits, by peer group, are used to calculate an audit disallowance factor. The audit disallowance factor is applied to each facility in the peer group.

Each annual long-term care rate is determined separately based on costs (except for the Pediatric Subacute rate, which uses a model, as described below). The rate for prior years is not used as the basis of the rate for the present year. Most facilities' cost reports are filed with the Office of Statewide Health, Planning and Development (OSHPD), and are made available to the Department for the annual rate setting process. The cost report information that the Department uses for the annual rate setting process is approximately two, to two and one-half years old. For this reason, the Department's projects each facility's costs for the upcoming rate year by utilizing this cost report data through data base analysis, review, and research on cost components and new program requirement costs.

Pediatric Subacute reimbursement is based on a model. The model projecting costs for Pediatric Subacute services was developed because of the limited cost data available for such services. The model is an estimate of the expected costs for this level of care and is updated each year based on selected update factors used for other levels of care.

COST COMPONENTS USED TO PROJECT COSTS

The adjusted long-term care costs are segregated into four categories: (1) fixed costs, which is comprised of interest, depreciation, leasehold improvements, and rent; (2) property tax; (3) labor expenses; and (4) all other costs. The rate methodology includes the development and use of established economic indicators to update costs from the midpoint of a facility's fiscal reporting period to the midpoint of the Medi-Cal rate year.

Under the federally approved State Plan rate setting methodology, rates for each rate year are based on projected costs for providers. Those projected costs are based on cost reports submitted by providers for a period approximately two years prior to the rate year. Various adjustments are applied to the reported costs, including inflation adjustments, as part of the process of determining each provider's projected costs for the rate year.

ADD-ONS

Additionally, the State Plan provides that adjustments or add-ons to projected costs will be made to reflect certain increases in provider costs that occurred after the cost reporting period. Under the State Plan, there are mandatory cost add-ons and discretionary cost add-ons.

The State Plan provides that when federal or state statutes or regulations impose new requirements on facilities after the cost reporting period, which add additional provider costs that would have not been reflected in provider cost reports used to establish the rates, projected costs must be increased by an appropriate add-on to reflect these additional costs. These cost add-ons, based on changes mandated by statute or regulation, are mandatory cost add-ons under the State Plan.

The State Plan also provides that the Department has the discretion to provide cost add-ons to projected costs to reflect "extraordinary costs" experienced by providers that would not have been reflected in the fiscal periods for the cost reports used to establish rates. When the Department was establishing the rates for the 2003-04 rate year, no add-ons were given.

The Department also concluded that the rates it established for the 2002-03 rate year were sufficient to assure that there would be enough long-term care providers to provide adequate access to quality long-term care services for Medi-Cal beneficiaries in need of such services. Thus, providing additional cost add-ons in order to further increase rates was unnecessary.

PROVIDER INPUT

The Department accepts input from industry representatives and organizations as part of the rate setting process. The California Association of Health Facilities, the California Hospital Association (previously known as California Healthcare Association), the Developmental Services Network, and Beverly Enterprises are among the groups that participated in discussions, or provided input to the Department's Medi-Cal Benefits, Waiver Analysis and Rates Division staff during the Department's rate setting process. The public notice of rate setting changes was published in the California Regulatory Notice Register on July 26, 2002 (Register 2002, Volume Number 30-Z).

SUPPORTING DOCUMENTATION

Listed below are the documents that the Department relied upon for this emergency action, including the studies performed during the annual rate setting process:

1) Report No. 01-03-01 (Study To Develop Labor Index For Long-Term Care Facilities).

2) Report No. 01-03-02 (Reimbursement Study for Long-Term Care Services).

3) State Plan Under Title XIX of Social Security Act, State: California, Reimbursement for all Categories of Nursing Facilities and Intermediate Care Facilities for the Developmentally Disabled (State Plan) Attachment 4.19-D TN 05-005 Approval Date September 9, 2005.

REFERENCE

1) Consumer Price Index:
http://www.dof.ca.gov/HTML/FSDATA/LatestEconData/FSPrice.htm

The regulations do not overlap or duplicate other existing state regulations.

The Department did not receive comments during the public proceedings, which commenced on July 16, 2010 and ended on September 3, 2010. A public hearing was not requested.

STATEMENTS OF DETERMINATION

A. ALTERNATIVES CONSIDERED

The Department has determined that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which this action is

proposed, or would be as effective and less burdensome to affected private persons than the emergency action.

B. LOCAL MANDATE DETERMINATION

The Department has determined that the emergency regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

C. ECONOMIC IMPACT STATEMENT

The Department has determined that the emergency regulations would not have a significant statewide adverse economic impact directly affecting businesses including the ability of California businesses to compete with businesses in other states.

The Department has determined that the emergency regulations would not significantly affect the following:

(1) The creation or elimination of jobs within the State of California.

(2) The creation of new businesses or the elimination of existing businesses within the State of California.

(3) The expansion of businesses currently doing business within the State of California.

This determination is made on the basis that the regulations reflect rate changes based upon reported costs that are prospectively updated for economic indicators and adjusted for audit results.

D. EFFECT ON SMALL BUSINESSES

The Department has determined that the emergency regulations would not affect small businesses. The regulations do not impose any additional reporting, recordkeeping, or other compliance requirements on small businesses.

E. HOUSING COSTS DETERMINATION

The Department has made the determination that the emergency regulations would have no impact on housing costs.