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Long Term Care

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Long Term Care Reimbursement Rates Update

Effective for dates of service on or after August 1, 2005, unless otherwise noted, reimbursement rates for the following services have changed:

- Nursing Facilities Level A (NF-A) and Level B (NF-B)
- Intermediate Care Facilities for Developmentally Disabled (ICF/DD)
- Intermediate Care Facilities for Developmentally Disabled-Habilitative (ICF-DD-H)
- Intermediate Care Facilities for Developmentally Disabled-Nursing (ICF-DD-N)
- Unlimited swing beds
- Subacute care, including pediatric subacute care

Leave of Absence and Bed Hold Rate Reduction
The rate reduction for leave of absence and bed hold for acute hospitalization is changed from $5.05 to $5.07 per diem for dates of service on or after August 1, 2004 and $5.18 per diem for dates of service on or after August 1, 2005.

Distinct-Part Nursing Facility
For an NF-B that is a distinct part of an acute care hospital, regardless of geographical location, payment is the lesser of either (1) the costs as projected by the Department of Health Services (DHS) or (2) the class median rate of $299.80, except for a state operated facility where payment is based on its allowable cost. Providers will be notified by the Department of Health Services (DHS) in a separate letter of their specific rates.

Subacute Facilities
Subacute and pediatric subacute providers will be reimbursed the lesser of their projected costs or the maximum reimbursement rate for each category of reimbursement. Providers will be notified by DHS in a separate letter of their specific rates.

Claims reimbursed at the previous rate for services rendered on or after August 1, 2004 will be automatically reprocessed.

This information is reflected on manual replacement pages rate facil diem 1 thru 6 (Part 2).

Rate Methodology and Rate Review Process

This Provider Bulletin outlines the Medi-Cal reimbursement rate calculation and rate review process, and also provides details, definitions, formulas, and other reporting requirements for Freestanding Nursing Facilities, Level-Bs (FS/NF-Bs), and Freestanding Subacute Nursing Facilities, Level-Bs (FSSA/NF-Bs) effective August 1, 2005 as mandated by *Health and Safety Code*, Sections 1324.20 through 1324.30. Unless otherwise stated, policies apply to both FS/NF-Bs and FSSA/NF-Bs.

Introduction

Welfare and Institutions Code Section 14126 through 14126.035 [Medi-Cal Long-Term Care Reimbursement Act, added by California Assembly Bill (AB) 1629 (Statutes of 2004, chapter 875)] authorizes the Department of Health Services (DHS) to implement a facility-specific rate setting system, subject to federal approval and the availability of federal funds, that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities, as defined in the *Health and Safety Code* Subdivision (c) of Section 1250. The facility-specific rate setting system will be effective August 1, 2005, and will be implemented on the first day of the month following federal approval. It is the intent of the Legislature to devise a Medi-Cal Long Term Care (LTC) reimbursement methodology that more effectively ensures individual access to appropriate LTC services, promotes quality resident care, advances decent wages and benefits for nursing home workers, supports provider compliance with all applicable state and federal requirements, and encourages administrative efficiency. *Welfare and Institutions Code* Section 14126.027(c) authorizes DHS to use provider bulletins as an alternative to regulations in order to implement the provisions of the statute. DHS is issuing this provider bulletin pursuant to this authority.

§200 Definitions

For purposes of these Instructions, the following definitions apply:

(a) "Skilled nursing facility" (SNF) means a health facility that provides skilled nursing care and supportive to patients whose primary need is for availability of skilled nursing care on an extended basis *Health and Safety Code* Section 1250(c); or is licensed to participate as a provider in Medicare.

(b) "Nursing Facility" (NF) means a health facility licensed pursuant to *Health and Safety Code* Section 1250 et seq. which DHS has certified to participate as a provider of care as either a skilled nursing facility to participate in Medicare or as a nursing facility in the federal Medicaid program or both.

(c) "Freestanding Nursing Facility" means a licensed and certified skilled nursing facility that is not part of an acute care hospital and that meets the standards of participation in Medi-Cal *Welfare and Institutions Code* Section 14091.21, *California Code of Regulations*, Title 22, Sections 51121 and 51215.

(d) "Freestanding Nursing Facility Subacute Care" means a licensed and certified skilled nursing facility which meets additional standards of participation to provide subacute care services, pursuant to *California Code of Regulations*, Title 22, Sections 51215.5 and 51215.6.

(e) "Distinct Part Nursing Facility" (DP/NF) means a distinct part or unit of a general acute care hospital or a acute psychiatric hospital as defined in Health and Safety Code Section 1250 (a) and (b), which DHS has licensed and certified either as a skilled nursing facility which meets the standards of participation set forth in *California Code of Regulations*, Title22, Section 51215, *California Code of Regulations*, Title 22, Section 51121; *California Code of Regulations*, Title 22, Section 70027, Distinct Part of a General Acute Care Hospital; Section 71027, Acute Psychiatric Hospital.

(f) "Distinct Part" means an identifiable unit accommodating beds and related facilities including, but not limited to, contiguous rooms, a wing, floor or building that is approved by the Centers for Medicare and Medicaid Services for a specific purpose. It must be operated under common ownership and control; the administrator and medical director must be accountable to the management of and it must be financially integrated with the institution of which it is a distinct part.

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(g) "Composite Distinct Part" means a distinct part consisting of two or more noncontiguous components not located within the same campus. A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part with only one provider agreement and only one provider number. If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations.

(h) "Publicly Owned and Operated Nursing Facility" (PUB) means a skilled nursing facility owned or operated by the state, city, county or city and county, University of California, hospital district or any other unit of government.

(i) "Routine Services" means the regular room, dietary, and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made.

(j) "Ancillary Services" means the services for which charges are customarily made in addition to routine services.

Description of Medi-Cal Facility-Specific Reimbursement Rate-setting System
§201 Facilities Subject to Facility-Specific Rate setting System
Freestanding Nursing Facility, Level-Bs (FS/NF-B), and Freestanding Subacute Nursing Facility, Level-Bs (FSSA/NF-B).

§202 Effective Date
The effective date of the facility-specific rate setting system is August 1, 2005.

§203 Basis for Facility-Specific Rate setting System Rate Reimbursement Methodology
Welfare and Institutions Code Section 14126.021 provides that DHS shall develop and implement a cost-based reimbursement rate methodology using the cost categories as described in Section 14126.023, for FS/NF-Bs and FSSA/NF-Bs pursuant to this article, excluding nursing facilities that are a distinct part of a facility that is licensed as a general acute care hospital as identified pursuant to subdivision (d) of Section 14126.02. The cost-based reimbursement rate methodology shall be effective on August 1, 2005, and shall be implemented on the first day of the month following federal approval. DHS will establish reimbursement rates pursuant to *Health and Safety Code*, Sections 1324.20 through 1324.30 on the basis of facility cost data reported on the Integrated LTC Disclosure and Medi-Cal Cost Report Office of Statewide Health Planning and Development (OSHPD disclosure report) required by *Health and Safety Code* Section 128730 for the most recent reporting period available and cost data reported in other facility financial disclosure reports, supplemental reports, or surveys required by DHS. The FS/NF-Bs and FSSA/NF-B actual reimbursement rate (per diem payment) is the amount DHS will reimburse for services rendered to an eligible resident for one resident day. The per diem payment is calculated prospectively on a facility-specific basis using facility-specific data from the FS/NF-Bs most recent cost report period (audited or adjusted), supplemental schedules, and other data determined necessary. For FSSA/NF-Bs data will be the most recent audit report data, supplemental schedules, and other data determined necessary.

Payment for FS/NF-Bs and FSSA/NF-Bs will be based on facility-specific cost-based reimbursement rates consisting of the five major cost categories. The per diem payment is comprised of five major cost categories:

1. Labor costs
2. Indirect care, non-labor costs
3. Administrative costs
4. Capital costs
5. Direct pass-through costs

The facility-specific cost-based per diem payment for FS/NF-Bs and FSSA/NF-Bs are based on the sum of the projected costs of the five major cost categories, each subject to ceilings. Costs within a specific cost category may not be shifted to any other cost category. In addition, per diem payments will be subject to overall limitations.

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§204 The Labor Cost Category

Labor costs. The labor cost category is comprised of a direct resident care labor cost component, an indirect care labor cost component, and a labor-driven operating allocation cost component. These components are comprised of more specific elements described below:

(a) Direct resident care labor costs of permanent full or part time facility employees include salaries, wages, and benefits related to routine nursing services personnel employed directly by the facility. Routine services include nursing, social services, and activities. Direct resident care labor costs include labor expenditures associated with permanent direct care employees. These services do not include expenditures associated with contract, registry or temporary agency staffing. These costs are limited to the 90th percentile of each respective peer-group. DHS will calculate the direct resident care labor daily payment from the FS/NF-Bs and FSSA/NF-Bs actual allowable Medi-Cal cost reported on the most recent published cost report, as adjusted for audit findings. The ceiling for each daily payment will be the 90th percentile of each peer-group allowable Medi-Cal direct resident care labor cost. DHS will reimburse each facility either at actual cost or the ceiling for its peer group, whichever is lower. DHS will also establish an inflation index, based on DHS labor study using the most recent industry-specific historical wage data as reported to OSHPD. DHS will apply this index to allowable direct resident care labor daily costs. Each facility's direct resident care labor costs will be increased from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

(b) Indirect care labor costs include ancillary labor costs related to the delivery of resident care including housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance costs. These costs are limited to the 90th percentile of each facility's respective peer-group.

In-service education activities means education conducted within the FS/NF-B and FSSA/NF-B for facility nursing personnel. Salaries, wages and payroll-related benefits of time spent in such classes by those instructing and administering the programs are included as in-service education labor costs. If instructors do not work full-time in the in-service education program, only the cost of the portion of time they spend working in the in-service education program is allowable. In-service education does not include the cost of time spent by nursing personnel as students in such classes or costs of orientation for new employees. The costs of nursing in-service education supplies and outside lecturers will be reflected in the in-service education non-labor costs of the indirect care non-labor cost category.

The indirect resident care labor per diem payment will be calculated from the FS/NF Bs and FSSA/NF Bs actual allowable Medi-Cal cost as reported on the facility's most recent cost report, as adjusted for audit findings. Each facility's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each facility's peer-grouped allowable Medi-Cal indirect resident care labor cost per diem. FS/NF-Bs and FSSA/NF Bs will be reimbursed the lower of their actual cost daily cost or the ceiling amount.

DHS will apply an inflation index to all allowable indirect resident labor costs of each facility. This inflation index will be based on a twice-yearly DHS labor study the most recent published industry-specific historical wage data reported to OSHPD. Each facility's indirect resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

(c) Labor-driven operating allocation includes an amount equal to eight percent of direct and indirect resident care labor costs, minus expenditures for agency staffing, such as nurse registry, contract services and temporary staffing agency costs. The labor-driven operating allocation may be used to cover allowable Medi-Cal expenditures incurred by a FS/NF-Bs and FSSA/NF-Bs to care for Medi-Cal residents. In no instance will the operating allocation exceed five percent of the facility's total Medi-Cal reimbursement rate.

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§205 Indirect Care Non-Labor Cost Category

Indirect care non-labor costs include the non-labor costs related to services supporting the delivery of resident care, including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education and plant operations and maintenance costs. These costs are limited to the 75th percentile of each facility's respective peer-group. The indirect care non-labor per diem payment will be calculated from the FS/NF-Bs and FSSA/NF-Bs actual allowable Medi-Cal cost as reported on the FS/NF-Bs most recently available cost report, as adjusted for audit findings. Each FS/NF-Bs and FSSA/NF-Bs per diem payment will be limited to a ceiling amount, identified as the 75th percentile of each FS/NF-Bs and FSSA/NF-Bs peer-grouped allowable Medi-Cal indirect care non-labor cost per diem. FS/NF-Bs and FSSA/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF-Bs and FSSA/NF-Bs allowable indirect care non-labor per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate year.

§206 Administrative Costs Category

Administrative costs include allowable administrative and general expenses of operating the facility, including FS/NF-Bs and FSSA/NF-Bs allocated expenditures related to allowable home office costs. The administrative cost category will include allowable property insurance costs, and exclude expenditures associated with caregiver training, liability insurance, facility license fees, and medical records. The administrative per diem payment will be calculated from the FS/NF-Bs and FSSA/NF-Bs actual allowable Medi-Cal cost as reported on the FS/NF-Bs and FSSA/NF-Bs most recent cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B and FSSA/NF-B will be peer-grouped (refer to the Section 213 Peer Grouping). Each FS/NF-Bs and FSSA/NF-Bs per diem payment will be limited to a ceiling amount, identified as the 50th percentile of the allowable Medi-Cal administrative cost per diem. FS/NF-Bs and FSSA/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

The *California Consumer Price Index for All-Urban Consumers*, as determined by the State Department of Finance, will be applied to the FS/NF-Bs and FSSA/NF-Bs allowable administrative per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate year.

§207 Capital Costs Category

Capital costs. A Fair Rental Value System (FRVS) will be used to reimburse FS/NF-Bs and FSSA/NF-Bs capital costs. Under the FRVS, DHS reimburses a facility based on the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, rent or lease payments. The FRVS establishes a facility's value based on the age of the facility. For rate years subsequent to 2005 – 2006, additions and renovations (subject to a minimum per-bed limit) will be recognized by lowering the age of the facility. The facility's value will not be affected by sale or change of ownership. Capital costs, limited as specified below, are derived from the FRVS parameters as follows: The initial age of each facility is determined as of the mid-point of the 2005 – 2006 rate year, using each facility's original license date, year of construction, initial loan documentation, or similar documentation. For the 2005 – 2006 rate year, all FS/NF-Bs and FSSA/NF-Bs with an original license date of February 1, 1976, or prior, will have five years subtracted from their facility age to compensate for any improvements, renovations or modifications that have occurred in the past. The age of each facility will be adjusted every rate year to make the facility one year older, up to a maximum age of 34 years.

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For the 2006 – 2007 and 2007 – 2008 rate years, costs incurred for major capital improvements, modifications or renovations equal to or greater than $500 per bed on a total licensed-bed basis will be converted into an equivalent number of new beds, effectively lowering the age of the facility on a proportional basis. If a facility adds or replaces beds, these new beds will be averaged in with the age of the original beds, and the weighted average age of all beds will represent the facility's age. If a facility performs a major renovation or replacement project (defined as a project with capitalized cost equal to or greater than $500 per bed, on a total bed basis), the cost of the renovation project will be converted to an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility.

The FRVS per diem calculation, subject to the limitations, is calculated as follows:

An estimated building value based on a standard facility size of 400 square feet per bed, each facility's licensed beds, and the R.S. Means Building Construction Cost Data, adjusted by the location index for each locale in the State of California. The estimated building value will be trended forward annually to the mid-point of the rate year using the change in the R.S. Means Construction Cost index.

An estimate of equipment value will be added to the estimated building value in the amount of $4,000 per bed. The greater of the estimated building and equipment value or the fully depreciated building and equipment value will be determined for each facility (hereinafter, the "current facility value"). The fully depreciated building and equipment value is based on a 1.8 percent annual depreciation rate for a full 34 years. An estimate of land value will be added to the current facility value based on ten percent of the estimated building value. A facility's fair rental value is calculated by multiplying the facility's current value plus the estimated land value, times a rental factor. The rental factor will be based on the average 20-year U.S. Treasury Bond yield for the calendar year preceding the rate year plus a two percent risk premium, subject to a floor of seven percent and a ceiling of 10 percent.

The facility's fair rental value is divided by the greater of actual resident days for the cost reporting period, or occupancy-adjusted resident days, based on the statewide average occupancy rate. Days from partial year cost reports will be annualized in the FRVS per diem payment calculation.

The capital costs based on FRVS will be limited as follows:

(a) For the 2005 – 2006 rate year, the capital cost category for all FS/NF-Bs and FSSA/NF-Bs in the aggregate will not exceed DHS' estimate of FS/NF-Bs and FSSA/NF-Bs capital reimbursement for the 2004 – 2005 rate year, based on the methodology in effect as of July 31, 2005.

(b) For the 2006 – 2007 and 2007 – 2008 rate years, the maximum annual increase for the capital cost category for all FS/NF-Bs and FSSA/NF-Bs in the aggregate will not exceed eight percent of the prior rate year's FRVS aggregate payment.

(c) If the total capital cost category for all FS/NF-Bs and FSSA/NF-Bs in the aggregate for the 2005 – 2006 rate year exceeds the value of the capital cost category for all FS/NF-Bs and FSSA/NF-Bs in the aggregate for the 2004 – 2005 rate year, DHS will reduce the capital cost category for each and every FS/NF-B and FSSA/NF-B in equal proportion.

(d) If the capital cost category for all FS/NF-Bs and FSSA/NF-Bs in the aggregate for the 2006 – 2007 or 2007 – 2008 rate year exceeds eight percent of the prior rate year's cost category, DHS will reduce the capital FRVS cost category for each and every FS/NF-B and FSSA/NF-B in equal proportion.

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Example of FRVS Per Diem Calculation

Example Assumptions

Building License Date = February 1, 1976
Actual Age on February 1, 2006 (mid-point of 2005/06 rate year) = 30 years
Effective Age for FRVS = 25 years (subtract 5 years for improvements)
Rental Factor = 7 percent
Construction Cost = $123 per square foot
Occupancy = 90% = 30,715 resident days
Licensed Beds = 99
Facility Location = San Diego = 1.061 location index

Base Value Computation

Estimated Building Value (99 beds x 400 square feet x $123 x 1.061)	$ 5,167,919
Add: Equipment Value at $4,000 per bed	$ 396,000
Gross Value	$ 5,563,919
Depreciation (1.8% x 25 years)	$ 2,503,764
Net Value (undepreciated current facility value)	$ 3,060,155
Add: Land Value at 10% of Undepreciated Building Value	$ 516,792
Total Base Value	**$ 3,576,947**

FRVS Per Diem Calculation

Fair Rental Value (rental factor x total base value)	$ 250,386
FRVS per diem (Fair Rental Value ÷ occupancy adjusted resident days)	**$ 8.15**

Example of FRVS Per Diem Calculation With Improvement Modification

Example Assumptions

Original Building Assumptions Remain Static	
Cost of Remodel	$ 500,000
Remodel Cost Per Bed ($500,000 ÷ 99 beds)	$ 5,051
Base Value Per New Bed Prior to Improvement Modification (gross value ÷ 99 beds)	$ 56,201

Modified Facility Age Calculation

Equivalent Number New Beds (cost of remodel ÷ base value/bed before improvement)	8.9

Weighted Average Age

Prior to Improvement – 99 Beds x 25 years	2,475
Resulting from Improvement – 8.9 Beds x 0 years	0
Total = 107.9 Beds	2,475
Weighted Average Age = 2,475/107.9	**22.9 Years**

Modified Base Value Computation

Gross Value (Building and Equipment)	$ 5,563,919
Adjusted Depreciation = 1.8% x 22.9 years x gross value	$ 2,293,447
Modified Net Value	$ 3,270,472
Add: Land Value	$ 516,792
Modified Total Base Value	**$ 3,787,264**

Modified FRVS Per Diem Calculation

FRVS per diem (Rental factor x modified base value)/(total resident days)	**$ 8.63**

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§208 Direct Pass-Through Costs.
Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, the Medi-Cal portion of the skilled nursing facility quality assurance fee, and new state and federal mandates for the applicable rate year.

The Medi-Cal proportional share of the pass-through per diem costs will be calculated as the FS/NF-Bs and FSSA/NF-Bs actual allowable Medi-Cal cost as reported on the FS/NF-Bs and FSSA/NF-Bs most recent available cost report and/or supplemental schedule(s), as adjusted for audit findings.

Caregiver training costs are defined as a formal program of education that is organized to train students to enter a caregiver occupational specialty. Until the Medi-Cal cost report is revised to specifically identify these costs, FS/NF-Bs and FSSA/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

The Medicare reimbursement principles consistent with Title 42, *Code of Federal Regulations*, Part 413 will be used to determine reasonable allowable pass-through costs for professional liability insurance. FS/NF-Bs and FSSA/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

The *California Consumer Price Index for All-Urban Consumers*, as determined by the State Department of Finance, will be applied to update caregiver training costs and liability insurance pass-through costs from the mid-point of the cost report period or supplemental report period to the mid-point of the rate year.

Property tax pass-through costs will be updated at the rate of two percent annually from the mid-point of the cost report period to the mid-point of the rate year.

Facility license fee pass-through costs and the Medi-Cal portion of the skilled nursing facility quality assurance fee will be applied on a prospective basis for each rate year, and will not require an inflation adjustment.

§209 Supplemental Schedules
On an annual basis, providers will be required to submit to DHS supplemental schedules which detail costs for selected categories. Those categories are: professional liability insurance, medical records, licensing fees, caregiver training, and agency employee support services applicable to plant operations and maintenance, housekeeping, laundry/linen, dietary, and in-service nursing education.

An additional schedule will be developed to capture capital costs. Further details on this issue will be issued in upcoming *Medi-Cal Update* bulletins.

Supplemental schedules will be completed based on the same fiscal period as the Medi-Cal disclosure report submitted to OSHPD, using forms furnished by DHS. Supplemental schedules are available on the DHS Web page at **www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**. These forms can be downloaded for completion. Forms should not be modified.

Further details on the Supplemental Schedules and their completion will be issued in upcoming Medi-Cal provider bulletins and notices.

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Rate Review *(continued)*

§210 FS/NF-B Cost Groupings

The following chart shows by cost category the OSHPD data source DHS uses to compute the facility-specific rates. For those costs not separately reported on an OSHPD line(s), supplemental schedules will be used. Only the SNF-attributable or FSSA/NF-B attributable costs will be used in the rate calculation.

Data Element	OSHPD Page, Line and Column(s)
Direct Resident Care Labor salaries, Wages and Benefits for:	
Skilled Nursing Care	10.1, line 105, columns 1 and 2
Social Services	10.1, line 155, columns 1 and 2
Activities	10.1, line 160, columns 1 and 2
Total - Nursing Services (agency staff)	12.2, line 435, column 2
Social Workers (agency staff)	12.2, line 555, column 2
Activity Program Leaders (agency staff)	12.2, line 560, column 2
Indirect Resident Care Labor Salaries, Wages and Benefits for:	
Plant Operations and Maintenance	10.1, line 5, columns 1 and 2
Plant Operations and Maintenance (agency staff) (1)	10.1, line 5, within column 3
Housekeeping	10.1, line 10, columns 1 and 2
Housekeeping (agency staff) (1)	10.1, line 10, within column 3
Laundry and Linen	10.1, line 60, columns 1 and 2
Laundry and Linen (agency staff) (1)	10.1, line 60, within column 3
Dietary	10.1, line 65, columns 1 and 2
Dietary (agency staff) (1)	10.1, line 65, within column 3
In-service Education	10.1, line 170, columns 1 and 2
In-service Education (agency staff) (1)	10.1, line 170, within column 3
Medical Records (2)	10.1, within line 165
Labor-Driven Operating Allocation Calculated based on 8 percent of Direct and Indirect Resident Care Labor, less the agency staff costs.	
Indirect Care Non-Labor Expenses for:	
Skilled Nursing Care	10.1, line 105, col. 14 (less 1 and 2)
Social Services	10.1, line 155, col. 14 (less 1 and 2)
Activities	10.1, line 160, col. 14 (less 1 and 2)
Plant Operations and Maintenance	10.1, line 5, col. 14 (less 1 and 2)
Housekeeping	10.1, line 10, col. 14 (less 1 and 2)
Laundry and Linen	10.1, line 60, col. 14 (less 1 and 2)
Dietary	10.1, line 65, col. 14 (less 1 and 2)
In-service Education	10.1, line 170, col. 14 (less 1 and 2)

(1) Indirect care agency expenses are not currently visible on the OSHPD Disclosure Report, and will be identified on a facility-specific basis using the Supplemental Schedule.

(2) Identified as expenditures that are currently not visible on the OSHPD Disclosure Report, and will be identified on a facility-specific basis using the Supplemental Schedule.

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Data Element	OSHPD Page, Line and Column(s)
Administrative expenses for:	
Property Insurance	10.1, line 45, column 14
Interest - Other	10.1, line 55, column 14
Administration	10.1, line 165, column 14
Capital:	
Reporting Period Begin Date	1, line 25
Reporting Period End Date	1, line 26
Facility Zip Code	1, line 8
Skilled Nursing Facility Medi-Cal Days	4.1, line 5, column 2
Total Skilled Nursing Facility Days	4.1, line 5, column 6
Total Facility Days	4.1, line 70, column 6
Average Licensed Beds	4.3(1), line 10, column 1
Pass-Through Costs:	
Property Taxes	10.1, line 40
License fees (2)	10.1, within line 165
Liability insurance (2)	10.1, within line 165
Caregiver Training (2)	10.1, within line 165

(2) Identified as expenditures that are currently not visible on the OSHPD Disclosure Report, and will be identified on a facility-specific basis using the Supplemental Schedule.

FSSA/NF-B Cost Groupings

The following chart shows by cost category the 2003 Audit Data source DHS uses to compute the facility-specific rates for FSSA/NF-Bs. For those costs not separately reported on an Audit line(s), supplemental schedules will be used.

Data Element	Schedule and Line Reference
Direct Resident Care Labor salaries, Wages and Benefits for:	
Skilled Nursing Care	Schedule 8, 125.01, 125.02
Social Services	Schedule 8, 155.01, 155.02 plus temp
Activities	Schedule 8, 160.01, 160.02 plus temp
Contracted Labor Nursing Personnel	Schedule 8, 125.03
Ancillary Direct Care Labor	SUB Sch 1, line 9
Indirect Resident Care Labor Salaries, Wages and Benefits for:	
Plant Operations and Maintenance	Schedule 8, 5.01, 5.02
Housekeeping	Schedule 8, 10.01, 10.02
Laundry and Linen	Schedule 8, 60.01, 60.02
Dietary	Schedule 8, 65.01, 65.02
In-service Education	Schedule 8, 170.01, 170.02
Medical Records *	10.1, within line 165

* Identified as expenditures that are currently not visible on the OSHPD Disclosure Report, and will be identified on a facility-specific basis using the Supplemental Schedule.

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Data Element	Schedule and Line Reference
Labor-Driven Operating Allocation Calculated based on 8 percent of Direct and Indirect Resident Care Labor, less the agency staff costs.	
Direct/Indirect Care Non-Labor Expenses for:	
Plant Operations and Maintenance Other non-labor	Schedule 8, 5.03
Housekeeping other non-labor	Schedule 8, 10.03
Laundry and Linen other non-labor	Schedule 8, 60.03
Dietary other non-labor	Schedule 8, 65.03
In-Service Education other non-labor	Schedule 8, 170.03
Skilled Nursing other non-labor	Schedule 8, 105.04
Social Services other non-labor	Schedule 8, 155.03 minus temp
Activities other non-labor	Schedule 8, 160.03 minus temp
Ancillary non-labor	SUB Sch 1, line 11
Administrative Expenses for:	
Admin Salaries and Wages	Sch 8, 165.01
Admin Benefits	Sch 8, 165.02
Admin other – non-labor	Sch 8, 165.06
Property Insurance	Sch 8, 45.00
Interest - Other	Sch 8, 55.00
Ancillary Admin	SUB Sch 6
Capital:	
Reporting Period Begin Date	1, line 25
Reporting Period End Date	1, line 26
Facility Zip Code	1, line 8
Skilled Nursing Facility Medi-Cal Days	4.1, line 5, column 2
Total Skilled Nursing Facility Days	4.1, line 5, column 6
Total Facility Days	4.1, line 70, column 6
Average Licensed Beds	4.3(1), line 10, column 1
Sub-Acute Care Medi-Cal Days	4.1, line 25, column 2
Total Sub-Acute Days	4.1, line 25, column 6
Pass-Through Costs:	
Property Taxes	SUB Sch1, line 5
License fees	Prospective Fee
Liability insurance	Sch 8, 165.04
Caregiver Training *	Supplemental

* Identified as expenditures that are currently not visible on the OSHPD Disclosure Report, and will be identified on a facility-specific basis using the Supplemental Schedule.

Please see **Rate Review**, *page 12*

§211 Limits or Caps on Facility-Specific Rates
The facility-specific Medi-Cal reimbursement rate calculated under the methodology will not be less than the Medi-Cal reimbursement rate that the FS/NF-B and FSSA/NF-B would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005 – 2006 and 2006 – 2007, respectively.

The aggregate facility-specific Medi-Cal payments calculated in accordance with this methodology will be limited by the following:

- For the 2005 – 2006 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed eight percent of the weighted average reimbursement rate for the 2004 –2005 rate year, as adjusted for the change in the cost to the FS/NF-B to comply with the skilled nursing facility quality assurance fee for the 2005 –2006 rate year, plus the total projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- For the 2006 – 2007 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed five percent of the weighted average Medi-Cal rate for the 2005 – 2006 rate year, as adjusted for the projected FS/NF-B and FSSA/NF-Bs Medi-Cal cost of complying with new State or federal mandates.
- For the 2007 – 2008-rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medi-Cal rate for the 2006 – 2007 rate year, as adjusted for the projected FS/NF-B and FSSA/NF-B Medi-Cal cost of complying with new state or federal mandates.

To the extent that the prospective facility-specific reimbursement rates are projected to exceed the adjusted limits calculated, DHS will adjust the increase to each FS/NF-Bs and FSSA/NF-Bs projected reimbursement rate for the applicable rate year by an equal percentage.

§212 Peer-Grouping
The percentile caps for FS/NF-B and FSSA/NF-B facility labor, indirect care non-labor, and administrative costs will be computed on a geographic peer-grouped basis. A more detailed explanation of the peer-grouping methodology is available on-line at: **www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**, or by contacting DHS at:

California Department of Health Services
Medi-Cal Policy Division/Long-Care System Development Unit
MS 4612
P.O. Box 997417
Sacramento, CA 95899-7417
Phone: (916) 552-9600

The seven peer groups are as follows:

Peer Group	County Name	County Number
1	Colusa	06
	Del Norte	08
	Imperial	13
	Kern	15
	Kings	16
	Lake	17
	Lassen	18
	Tulare	54
	Yuba	58

Please see **Rate Review**, *page 13*

Rate Review *(continued)*

Peer Group	County Name	County Number
2	Butte	04
	Humboldt	12
	Inyo	14
	Madera	20
	Mendocino	23
	Merced	24
	San Luis Obispo	40
	Tehama	52
	Yolo	57
3	Calaveras	05
	Glenn	11
	Plumas	32
	San Joaquin	39
	Shasta	45
	Siskiyou	47
	Stanislaus	50
	Sutter	51
	Ventura	56
4	Amador	03
	El Dorado	09
	Nevada	29
	Placer	31
	Tuolumne	55
5	Los Angeles	19
6	Fresno	10
	Orange	30
	Riverside	33
	San Bernardino	36
	San Diego	37
	Santa Cruz	44
	Solano	48
7	Alameda	01
	Contra Costa	07
	Marin	21
	Monterey	27
	Napa	28
	Sacramento	34
	San Francisco	38
	San Mateo	41
	Santa Barbara	42
	Santa Clara	43
	Sonoma	49

There are no Medi-Cal FS/NF-B and FSSA/NF-B facilities for counties not listed.

Please see **Rate Review**, *page 14*

§213 Determination of FS/NF-B Rates for State-Owned Facilities, Newly Certified Providers or Changes of Ownership

State-owned and operated skilled nursing facilities will receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate.

New FS/NF-Bs and FSSA/NF-Bs with no cost history in a newly constructed facility or an existing facility newly certified to participate in the Medi-Cal program will receive an interim reimbursement rate based on the peer-grouped weighted average Medi-Cal reimbursement rate. Once the FS/NF-B has submitted six months of cost and/or supplemental data, its facility-specific rate will be calculated according to the methodology set forth in this Supplement. The difference between the FS/NF-Bs interim per diem payment rate and the facility-specific per diem payment rate will be determined upon audit or review of the cost report and/or supplemental report. DHS will adjust the difference in reimbursement rate on a prospective basis.

Changes of ownership or changes of the licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. In instances where the previous provider participated in the Medi-Cal program, DHS will reimburse the new owner or operator the per diem payment rate of the previous provider until the new owner or operator has submitted at least six months of cost and/or supplemental data. If, upon audit or review, the per diem payment rate calculated for the new owner/operator is less than the per diem payment rate of the previous owner/operator, DHS will adjust the new owner's or operator's per diem payment rate.

§214 Change in Facility Fiscal Period

Facilities that change their cost report period may file two OSHPD reports. For example, if the fiscal period end date changes from March 31, 2004 thru December 31, 2004, a disclosure reports may be filed for the period April 1, 2003 thru March 31, 2004 and a second report for the period of April 1, 2004 through December 31, 2004. DHS will use the most recent period available if it contains more than six months of data. If the newest report contains less than six months of data, the earlier period will be used.

§215 Reimbursement Rate Review Process

A facility may request that DHS conduct a Reimbursement Rate Review if it contends errors were made during the interim reimbursement rate calculations. Upon issuance of the Medi-Cal interim reimbursement rate, providers will have until November 15, 2005 to file a Rate Review request using the form specified in Section 217. Rate Reviews will be accepted only for errors made by DHS during the interim rate calculation. For example, if DHS applied the OSHPD cost report data to the wrong facility due to an incorrect OSHPD number.

Rate Reviews are not an audit; therefore, the audit appeal provisions contained in *Welfare and Institutions Code* Section 14170 et seq. do not apply. Facilities have an opportunity to appeal cost report audit findings pursuant to *Welfare and Institutions Code* Section 14170 et seq.; only after Audits and Investigations Financial Branch completes its audit of the facility. Audited cost report data from the Financial Audits Branch will be conclusively presumed correct for purposes of the Rate Review.

Facilities may challenge the validity of the audited cost report data only through the Audit Appeal process contained in *California Code of Regulations*, Title 22, Section 51016.

Rate Reviews will not be accepted to correct OSHPD cost report data, supplemental schedules or audited cost report data. This data will also be conclusively presumed correct for purposes of the Rate Review. For example, if the OSHPD cost report data claimed $50,000 for insurance, but the actual amount was $75,000 DHS will not authorize a Rate Review.

DHS may request additional information if necessary within 15 days of the provider's request. DHS shall render a decision within 60 days after receiving all required or requested information. The decision shall identify the specific issues in dispute, rule on each issue, state the facts supporting each ruling and identify the pertinent statutory and regulatory authority.

The Rate Review Process will be the final level of review within DHS.

Please see **Rate Review**, *page 15*

§216 Instructions for Reimbursement Rate Review Process for FS/NF-B or FSSA/NF-B Facilities

Any FS/NF-B or FSSA/NF-B facility may request a rate review, if data from the OSHPD cost report, audited cost report, or the Supplemental Schedules were not properly used in the facility-specific rate calculation. The FS/NF-B or FSSA/NF-B must show that DHS calculated the rate incorrectly using data that the facility submitted. Any FS/NF-B or FSSA/NF-B cannot use the Rate Review Process to correct or amend the data it submitted in its OSHPD cost report or supplemental schedules.

The following examples warrant rate review:

- A provider reported $20,000 for caregiver training on the Supplemental Schedule, but these costs were not used as a pass-though cost.
- Another example of a valid review request would be, if the data submitted were applied to the wrong provider due to an incorrect OSHPD number.

§217 Rate Review Form

A *Rate Review Form* must be filed in writing to DHS no later than November 15, 2005. The form shall contain pertinent facility information, including the provider's OSHPD number, the fiscal period end date, identification of the rate error, and the specific basis for the Rate Review. All supporting documentation and justification necessary to warrant a Rate Review must be submitted with the *Rate Review Form*. The Rate Review Form is included with this provider bulletin and can be downloaded from the DHS Web site at: **www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**, or can be requested by leaving a voice mail message at (916) 552-8613.

Rate Review Forms must be sent in writing to:

Department of Health Services
Medi-Cal Policy Division/Long Term Care
System Development Unit
MS 4612
1501 Capitol Avenue, Suite, 71.4001
P.O. Box 997417
Sacramento, CA 95899-7417

Please see **Rate Review**, *page 16*

Rate Review *(continued)*

Department of Health Services

Request for AB 1629 Rate Review

Mail Request and Supporting Documentation to:

Department of Health Services
Medi-Cal Policy Division/Long Term Care System
Development Unit
MS 4612
1501 Capitol Avenue, Suite 71.4001
P.O. Box 997417
Sacramento, CA 95899-7417

Facility Name (DBA) »

OSHPD ID »

Medi-Cal Provider Number »

Report Period End Date»

Contact Person »

E-mail »

Phone Number »

Date of Request »

Facility Type »

- ☐ **Freestanding NF-B**
- ☐ **Subacute Care Unit of Freestanding NF-B**

Request for Review of Following Areas (check box) »

- ☐ **Direct Care Labor Per Diem**
- ☐ **Indirect Care Labor Per Diem**
- ☐ **Direct/Indirect Non-Labor Per Diem**
- ☐ **Administration Per Diem**
- ☐ **FRVS Per Diem**
- ☐ **Property Tax Per Diem**
- ☐ **Liability Insurance Per Diem**
- ☐ **Caregiver Training Per Diem**
- ☐ **Quality Assurance Fee Per Diem**
- ☐ **License Fee Per Diem**
- ☐ **Hold-Harmless Rate**
- ☐ **Labor-Driven Operating Allocation**
- ☐ **Application of Facility-Specific Audit Adjustment**
- ☐ **Other »**

For each request identified above provide a detailed explanation of the specific basis for the rate review. If you are submitting a rate review request for multiple facilities, identify which facilities (by OSHPD ID) are affected by each issue.

Note that the rate review process should not be used to correct or amend data submitted on the OSHPD LTC Facility Integrated Disclosure and Medi-Cal Cost Report or Supplemental Schedules. The review process also cannot be used to appeal findings which were or could have been addressed during the provider audit process.

Long Term Care Bulletin 343

Remove and replace:
appeal form 1/2 **, 7/8 **
cif sp ltc 3 thru 8 *
leave 5 thru 8 *
medi cr ltc 5 thru 8 *, 11/12 *
rate facil diem 1 thru 6
rural hosp 1/2 **
sub acut lev 3/4 **
tar crit nf 7/8 **
tar field1/2 **

* Pages updated due to ongoing provider manual revisions.
** Pages updated due to ongoing provider manual revisions. County Medical Services Program (CMSP) providers should remove these pages but retain them in the Appendix of their provider manual for future reference.