

**DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION DOCUMENT FOR
ADDITIONAL HEALTH CARE COVERAGE COST
DUE TO THE AFFORDABLE CARE ACT (ACA)
FOR 2015 & 2016 CALENDAR YEARS**

REQUIREMENTS AND INSTRUCTIONS FOR QUALIFYING PROVIDERS

Background

The Department of Health Care Services (DHCS) is collecting information to determine add-on reimbursement eligibility for additional cost incurred by long-term care providers due to the new Affordable Care Act (ACA) health care coverage requirement. Section 6056 of the Internal Revenue Code (IRC), was added to the Employer Shared Responsibility provision under section 4980H, and applies to health coverage provided by Applicable Large Employers as defined by 4980H and its implementing regulations and guidance.

For more information on the employer shared responsibility regulations please see the [*Federal Register Vol. 9. No. 29.*](#)

Certification Form Requirements

A provider may submit this Certification Form for reimbursement if it is an Applicable Large Employer as defined by 4980H and its implementing regulations, and if the provider incurred additional costs due to this ACA requirement.

Do not submit this form if your facility did not have additional costs due to the ACA.

The reimbursement calculation will be based on the additional cost of health insurance due to this ACA requirement and the provider's total inpatient days from Rate Year 2015-16 or Rate year 2016-17, depending on when the Certification Form is submitted. The add-on will be a 2 year add-on to the facilities rate until the ACA costs are included in their cost report.

Reporting Period

The reporting period for the Certification Form is January 01, 2015, to December 31, 2015, and January 1, 2016, to December 31, 2016, for Applicable Large Employers.

Guidance for Providers with Multiple Facilities

If a provider meets the employment and additional cost requirement and has multiple facilities, it must submit a Certification Form for each facility location. Status as an Applicable Large Employer is based on total number of employees; however, the facility-specific reimbursement will be based on the additional health coverage cost for each facility.

Multiple Levels of Care

Providers should submit a separate Certification Form for each level of care. For example, a SNF-B with Adult Subacute beds and SNF-B cost should submit separate Certification Forms.

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Different Categories of Service

Providers should only report costs incurred for their long-term care services. For example, for a Skilled Nursing Facility - Distinct Part of a General Acute Care hospital (DPNF) the number of employees and costs incurred should only be related to the DPNF and not the entire hospital.

Certification Form Submission Instructions

Submission instructions for all providers types except Intermediate Care Facilities/Developmental Disability (ICF/DD):

Complete the electronic Certification Form and save it using the facility's OSHPD number (e.g., 206xxxxxx). Submit to the Department of Health Care Services by **January 15, 2016**, for costs incurred in calendar year 2015 and 2016.

Submission instructions for ICF/DDs including Habilitative and Nursing:

Complete the electronic Certification Form, and save it using the facility's National Provider Identifier (NPI) and 9-digit zip code (e.g., 10437xxxxx-95814-1114), and submit to the Department by **January 15, 2016**, for costs incurred in calendar year 2015 and 2016.

Instructions for all provider types:

- If there are multiple facility locations, the authorized persons must submit a form for each facility location.
- You may submit electronically to supp1629@dhcs.ca.gov and on the subject line enter "ACA Certification Form" along with your facility's OSHPD number (e.g. ACA Certification Form 206xxxxxx). Or if you are not able to submit electronically please mail a signed copy of the Certification Form and printed copies of the Excel spreadsheet to:

Department of Health Care Services
Fee-For-Service Rates Development Division
Long Term Care Section
ACA Cert Form
P.O. Box 997417, Suite 71.3052, MS 4600
Sacramento, CA 95899-7417

Instructions for Completing the Certification Form

This form certifies that a provider is an Applicable Large Employer and additional costs were incurred due to the ACA's health care coverage requirements. Providers or facilities with a common owner or that are otherwise related under certain rules of section 414 of the IRC are generally combined and treated as a single employer for determining the number of employees. A provider should review these rules and to determine whether to count employees working in facilities, work programs, transportation programs and other business models, units or programs that are under the same ownership.

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Do not alter the tab names or data descriptions in the Excel workbook. Altered worksheets will be rejected and excluded from the rate calculation.

Section A. Facility information

1. Enter the facility's name, address and OSHPD/NPI information.
2. Select the type of Long Term Care Facility from the drop down menu.
3. Indicate if the employer owns multiple facilities.
4. Select the category of insurance carrier used to cover employees from the drop down menu.
5. Enter the health insurance policy number, the date the policy began and the date the policy will end or need to be renewed.

Note: Continuity of Coverage

Providers are required to notify the Department of Healthcare Services in writing if the health insurance coverage is discontinued for any reason.

Section B. Authorized person to fill out the Form

1. A facility administrator or other authorized person filling out the form.
2. A health insurance agent licensed by the California Department of Insurance (CDI) may qualify as an authorized person. Go to CDI's [Agents & Brokers: License and Status Inquiry website](#) to obtain and view details on a license.

Section C. Provider's Status

1. Check the box if the provider is an Applicable Large Employer in calendar year 2015.
2. Check the box if the provider is an Applicable Large Employer in calendar year 2016.

Section D. Cost Information

1. Enter the annual cost of providing Health Care Insurance/Coverage for employees in calendar year 2014.
2. Enter the new cost of Providing Health Care Insurance/Coverage for employees in calendar year 2015. The new cost should be determined by calculating the difference between calendar year 2014's cost and calendar year 2015's cost for an Applicable Large Employer in 2015.
3. Enter the new cost of Provided Health Care Insurance/Coverage for employees in calendar year 2016. The new cost should be determined by calculating the difference between calendar year 2015's cost and calendar year 2016's cost for an Applicable Large Employer in 2016.

The figures certified are subject to DHCS' review for the purposes of this add-on calculation. DHCS reserves the right to request additional information before reimbursing the add-on and may request an audit of the amounts declared. DHCS may recover any overpayments which are not increased costs resulting from ACA mandate

**CERTIFICATION FORM
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Section E. Authorized signature

1. Please type your name as your electronic signature it will be accepted under penalty of perjury.
2. Please enter your title and date of signature.
3. If printing and submitting by mail, please sign the form in blue or black ink it will be accepted under penalty of perjury.

For assistance, please contact the Long Term Care System Development Unit at supp1629@dhcs.ca.gov.