FINAL STATEMENT OF REASONS

Title XIX of the Social Security Act provides for the federal Medicaid program, administered in California by the California Department of Health Care Services (Department), as the California Medical Assistance (Medi-Cal) program. The Medi-Cal program provides qualified low-income persons (primarily families with children and the aged, blind, or disabled) with health care services. Under the authority of federal statutes, and regulations, and state law, each State adopts regulations: 1) establishing eligibility standards; 2) determining the type, amount, duration, and scope of services; 3) setting the rate of payment for services; and 4) administering the program.

Assembly Bill (AB) 1629 (Chapter 875, Statutes of 2004) added Health and Safety (H&S) Code, Sections 1324.20 through 1324.30, which establishes the Quality Assurance Fee (QAF) Program that requires the Department to collect funds from licensed skilled nursing facilities as a means to enhance federal financial participation for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities.

Also, AB 1629 added Welfare and Institutions (W&I) Code, Sections 14126 through 14126.035, the Medi-Cal Long-Term Care (LTC) Reimbursement Act for skilled nursing facilities, which mandates that the Department establish a facility-specific rate-setting system that reflects the costs and staffing levels associated with quality care for residents in skilled nursing facilities. Establishing a facility-specific rate more effectively ensures individual access to appropriate LTC services, promotes quality resident care, advances wages and benefits for facility staff, supports provider compliance with all applicable state and federal requirements, and encourages administrative efficiency.

The Department was granted authority to implement the provisions under AB 1629 through use of Provider Bulletins, which has been the current practice.

AB 1183 (Chapter 758, Statutes of 2008) extended the Department’s authority to implement the QAF Program and the Medi-Cal LTC Reimbursement Act through Provider Bulletins until July 31, 2010. The legislature directed that emergency regulations be adopted on or before July 31, 2010. The emergency adoption of DHCS-06-102E was effective July 22, 2010 (OAL File #2010-0712-02E).

Senate Bill (SB) 853 (Chapter 717, Statutes of 2010) extended the QAF Program and the Medi-Cal LTC Reimbursement Act until July 31, 2012. In addition, SB 853 revised and implemented changes to the rate reimbursement methodology, QAF program and the new quality and accountability payment system. These changes were reflected in the re-adoption of the emergency regulations effective January 18, 2011 (OAL File # 2010-1231-01EE).

This regulatory action was set forth as an emergency as a result of the following: H&S Code Section 1324.23(b), which allows the Department to adopt emergency regulations to implement Article 7.6, Skilled Nursing Facility Quality Assurance Fee; W&I Code, Section 14105, which requires the Department adopt emergency regulations to set rates that reflect legislative budgeting decisions; and W&I Code, Section 14126.027(b)(1), which authorizes the adoption of regulations to implement Article 3.8, Medi-Cal LTC Reimbursement Act and specifies such an adoption is deemed necessary for the immediate preservation of the public peace, health and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code.

This Certificate of Compliance makes permanent the emergency regulations and proposed amendments under Title 22, California Code of Regulations (CCR), Article 9, Sections 52000, 52100 through 52104, 52500 through 52516, and 52600.

The specific purpose and rationale for each section are identified below.

SUPPORTING DOCUMENTATION

The Department utilized different resources in the development and implementation of the QAF Program and facility-specific rate-setting system. Listed below are the resource documentation that the Department relied upon in the development of the QAF Program and facility-specific rate-setting system regulations:

- Centers for Medicare & Medicaid Services (CMS) Provider Reimbursement Manual Part 1, Publication 15-1, accessible at: www.cms.gov/manuals/pbm/list.asp

- Centers for Medicare & Medicaid Services (CMS) Publication 13, Part 2, Audits Reimbursements/Program Administration, accessible at: www.cms.gov/manuals/pbm/list.asp

  The CMS Manual System is used by CMS program components, partners, contractors, and State Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on federal statutes and regulations, guidelines, models, and directives. The guidelines and policies outlined in these CMS Manuals are also cross referenced in the State Plan Supplement 4 to Attachment 4.19-D (further discussed below).

- Study to Develop Labor Index for Long-Term Care Facilities, 2009-10 Rate Study, Report Number 01-09-01 (April 2009)

  The Department's labor study, encompassing the most recently available industry specific historical wage data as reported to the Office of Statewide Health Planning and Development (OSHPD) by providers, is used for multiple departmental operations, including the development of a labor inflation index as defined in Section 52000(r) and described throughout Section 52502. The labor inflation index is used to inflate or project allowable labor costs (labor costs specified within Section 52502) from past cost reporting period mid-points to approximations of subsequent reporting period mid-points, as a basis for current or future years' provider reimbursement labor components.

- Study to Develop Labor Index for Long-Term Care Facilities, 2010-11 Rate Study, Report Number 01-10-01 (August 2010)

  The Department's labor study, encompassing the most recently available industry specific historical wage data as reported to OSHPD by providers, is used for multiple departmental operations, including the development of a labor inflation index as defined in Section 52000(r) and described throughout Section 52502. The labor inflation index is used to inflate or project allowable labor costs (labor costs specified within Section 52502) from past cost reporting period mid-points to approximations of subsequent reporting period mid-points, as a basis for current or future years' provider reimbursement labor components.

- State Plan Supplement 4 to Attachment 4.19-D, effective August 1, 2005, accessible at:
  http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Section%204.aspx

  The Medicaid State Plan is based on the requirements set forth in Title XIX of the Social Security Act and is a comprehensive written document created by the State of California that describes the nature and scope of its Medicaid (Medi-Cal) program. It serves as a contractual agreement between the State of California and the federal government and must be administered in conformity with specific requirements of Title XIX of the Social Security Act and regulations outlined in Chapter IV of the Code of Federal Regulations. The State Plan contains all information necessary for CMS to determine if the State can receive Federal Financial Participation (FFP).

  H&S Code Sections 1324.27 and 1324.28 and W&I Code Section 14126.025 require the Department to obtain federal approval from CMS in order to implement and continue the QAF Program and the Medi-Cal Long-Term Reimbursement Act. The State Plan was the tool the Department used to obtain the required federal approval. State Plan Supplement 4 to Attachment 4.19-D outlines the federally approved Methods and Standards for Establishing Facility-Specific Reimbursement Rates for Freestanding Skilled Nursing Facilities Level-B and Subacute Care Units of Freestanding Skilled Nursing Facilities. The State Plan Supplement 4 to Attachment 4.19-D includes numerous cross-references to the CMS Manuals (discussed above); thereby assuring the Department's compliance with CMS policies and procedures and with federal laws and regulations.

- Office of Statewide Health Planning and Development (OSHPD) Accounting and Reporting Manual for California Long-Term Care Facilities (December 2000), accessible at: http://www.oshpd.ca.gov/HID/Products/LTC/Manual/index.html

This OSHPD manual provides the uniform accounting and reporting system required to be implemented by all California skilled nursing and intermediate care facilities. Under the requirements of H&S Code, Part 1.8, Health Data and Advisory Council Consolidation Act, OSHPD is responsible for developing and maintaining systems of long-term care facility uniform accounting and reporting. The Act requires all California long-term care facilities, except those specifically exempted, to implement and use OSHPD's uniform accounting system in their books and records on a day-to-day basis as prescribed in this manual.

- Frequently Asked Questions (FAQ's) regarding the Capital Supplemental Schedule for the 2008-2009 Rate Year accessible at: http://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629/2008%2009%20Capital%20Sup%20Sch%20FAQ.pdf

  The FAQ's regarding the Capital Supplemental Schedule for the 2008-2009 Rate Year provides clarification to providers who intend to submit the "Capital Additions, Improvements, and Replacements" form. The form is required for Medi-Cal providers who wish to claim specified expenditures within the Fair Rental Value System (FRVS) component of the facility-specific rate computation. The FAQ's document offers answers to questions providers often have in relation to the general capital supplemental schedule, in addition to the specific reporting requirements within several categories of the form. The FAQ's document originated from the 2008-2009 rate year, and continues to be applicable.

REFERENCES

Listed below are the resources that the Department references within this emergency action:

- R.S. Means Building Construction Cost Index, accessible at: rsmeans.com or http://rsmeans.reedconstructiondata.com/

  This Index is construction estimating software that updates on an annual basis and is available online to purchased subscribers. It is an estimating tool with online access to the R.S. Means database of unit costs, assemblies, repair and remodeling costs.

- California Consumer Price Index (CPI) for All-Urban Consumers, accessible at: http://www.dir.ca.gov/dlsr/CPI/faqs.htm#q1

  The CPI is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. The CPI affects nearly all Californians, and may be used as: an economic indicator, a deflator of other economic series, a means of adjusting dollar values, and many other economic/cost related uses.

Adopt Section 52000. Definitions.

The proposed adoption of Title 22, CCR Section 52000 is necessary to provide the following definitions that will offer a uniform interpretation and conformity of the terms as they are used throughout Chapter 3. Article 9. These definitions have been developed in accordance with the Medi-Cal Long-Term Care Reimbursement Act (W&I Code Sections 14126.02 and 14126.031) that authorizes the use of professional consulting services in the establishment of the long-term care reimbursement system.

Subsection (a) is proposed to be adopted to define “Administrator Compensation” as a component of the Administrative Costs Category under the long-term care rate methodology as specified in Section 52504. This definition is consistent with the State Plan Supplement 4 to Attachment 4.19D, page 4 effective August 1, 2005. Section IIIJ states that “for purposes of calculating reasonable compensation of facility administrators, the Department will adhere to the standards established under Chapter 9 of the CMS Provider Reimbursement Manual Part 1, Publication 15-1 (CMS Publication 15-1). This definition incorporates the various elements described in Chapter 9 of CMS Publication 15-1 and is commonly used and understood by the long-term care stakeholders as it is further described under Section 52504 below.

Subsection (b) is proposed to be adopted to define “Administrative Costs” as a cost category of the facility-specific rate methodology in accordance with W&I Code Section 14126.023 and as specified in Sections 52501 and 52504. The items included in this definition are the result of consultation with long-term care stakeholders and are commonly used and understood in the long-term care community. This definition incorporates items from the definition of “Administration Cost Center” from the OSHPD Accounting and Reporting Manual for Long-Term Care Facilities Sections 3220.2 and 3220.3, to ensure the Department’s standards/terms are consistent with those of OSHPD. Through the re-adoption of the emergency regulations on January 18, 2011, the phrase “liability insurance deductibles” was removed to be consistent with W&I Code Section 14126.023(a)(5)(B).

Subsection (c), as initially adopted on July 22, 2010 to define “Assisted Living Services”, was repealed through the re-adoption of the emergency regulations on January 18, 2011. This repeal was necessary to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically H&S Code Sections 1324.20(c) and 1324.21(a), which eliminated the QAF exemption for a Multi-Level Retirement Community (MLRC).

Subsection (c), (originally (d)) is proposed to be adopted to define “Audited Cost Report Data” as specified in Section 52500. W&I Code Section 14126(i) requires the Department to conduct financial audits on the facility’s cost reports and to adjust facility-specific rates based on audit results. This phrase and definition simply specify that the data used in rate-setting is data that is the result of Department audits that is contained in a report. The term “audited cost report data” is commonly used and understood in the long term-care community to describe data used to determine facility-specific rates.

Subsection (d) (originally (e)) is proposed to be adopted to define “Benchmark” as specified in Sections 52502, 52503, 52504 and 52507. W&I Code Section 14026.023(a)(1) – (3) and (5) establishes percentile limits on three cost categories in the facility-specific rate-setting methodology. The term “Benchmark” is the current business terminology for these percentile limits and is commonly used and understood in the long-term care community.

Subsection (f) as initially adopted on July 22, 2010 to define “Business Practice” was repealed through the re-adoption of the emergency regulations on January 18, 2011. This repeal was necessary to be consistent with SB 853 (Chapter 717, Statutes 2010), specifically H&S Code Section 1324.20(c), which eliminated the QAF exemption for an MLRC.

Subsection (e) (originally (g)) is proposed to be adopted to define “Capital Costs” as specified in Sections 52501 and 52505. W&I Code Section 14126.03(f) requires “Capital Costs” be based on the FRVS. Based on the Department’s experience in implementing the FRVS, it was determined that some of the definitions from the cost centers of the OSHPD Accounting and Reporting Manual for Long-Term Care Facilities Sections 3220.3 and 3220.4 needed to be included in the “Capital Costs." The term “Capital Costs” and the items that are included in determining these costs are commonly understood in the long-term care community.

Subsection (f) (originally h) was initially proposed to be adopted to define “Captive Insurance Policies” as initially specified under Section 52506. Through the 15-Day Public Availability published on February 17, 2011 this subsection was removed as a result of collaboration and recommendation from stakeholders and to be consistent with the removal of Section 52507(f) (see explanation for changes to Section 52507(f) below).

Subsection (g) (originally (i)) was initially adopted on July 22, 2010 to define “Certificate of Authority.” This subsection was repealed through the 15-Day Public Availability, published on February 17, 2011. This repeal was necessary to be consistent with H&S Code Section 1324.20(c), which eliminated the QAF exemption for an MLRC.

Subsection (h) (originally (j)) as initially adopted on July 22, 2010 to define “Corporate Structure,” was repealed through the 15-Day Public Availability, published on February 17, 2011. This repeal was necessary to be consistent with H&S Code Section 1324.20(c), which eliminated the QAF exemption for an MLRC.

Subsection (i) (originally (k)) as initially adopted on July 22, 2010 to define “Current Facility Value,” was repealed through the 15-Day Public Availability, published on February 17, 2011. This repeal was a result of the review of a 45-Day public comment pertaining to the clarity and use of this definition, after which it was determined that the definition is not necessary, thus it is removed. Section 52505(a)(4) clearly states how the Department determines the current facility value.

Subsection (f) (originally (l)) is proposed to be adopted to define “De-Certified” as referred to in Section 52511 that pertains to rate-setting for facilities. De-certified facilities are not subject to the facility-specific rate-setting methodology. The term “de-certified” is commonly understood by long-term care stakeholders as a facility that is no longer certified to participate in the Medi-Cal program.

Subsection (g) (originally (m)) is proposed to be adopted to define “Direct Care Agency Costs” as specified in Section 52502. Through practical experience and consultation with long-term care stakeholders it was determined there were additional costs needed under the facility-specific rate methodology. These costs were categorized as “Direct Care Agency Costs.” The term “Direct Care Agency Costs” and the items included in this cost category are commonly understood in the long-term care community.

Subsection (h) (originally (n)) is proposed to be adopted to define “Direct Care Labor Costs” as specified in Section 52502. W&I Code Section 14126.023 establishes the items to be included as direct care labor costs, however through practical experience and consultation with long-term care stakeholders, it was determined that the definition of direct care labor costs needed to be further defined. The term “Direct Care Labor Costs” and the items included in this cost category are commonly understood by the long-term care community.

Subsection (i) (originally (o)) is proposed to be adopted to define “Direct and Indirect Care Non-labor Costs” as specified in Section 52501. W&I Code Section 14126.023 establishes Indirect Care Non-labor Costs as a cost category for the facility-specific rate methodology. Through practical experience and consultation with long-term care stakeholders this cost category and the items included in determining the costs was revised to also include “direct” care non-labor costs. The phrase “Direct and Indirect Care Non-labor Costs” and the items included in this cost category are commonly understood by the long-term care community.

Subsection (j) (originally (p)) is proposed to be adopted to define “Direct Pass-Through Costs for Care Giver Training” as specified in Section 52506. W&I Code Section 14126.023 specifies direct pass-through costs for determining facility-specific rates and includes proportional Medi-Cal costs for caregiver training as a direct pass-through. This definition was developed in consultation with long-term care stakeholders and is consistent with the OSHPD Accounting and Reporting Manual for California Long-Term Care Facilities Section 1142. The term “Direct Pass-Through Costs for Care Giver Training” defines the allowable pass-through costs and is commonly understood within the long-term care community.

Subsection (k) (originally (q)) is proposed to be adopted to define “Direct Pass-Through Costs for Facility License Fees” as specified in Section 52506. W&I Code Section 14126.023 identifies facility license fees as a direct pass-through cost. This proposed definition simply clarifies that the fee for a facility license, which is paid annually, is included in the pass-through costs.

Subsection (r) as originally adopted July 22, 2010 to define “Direct Pass-Through Costs for Liability Insurance,” was repealed through the re-adoption of the emergency regulations on January 18, 2011. This repeal was necessary to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(a)(5)(B) that eliminated liability insurance as a direct pass-through cost.

Subsection (l) (originally (s)) is proposed to be adopted to define the “Fair Rental Value System (FRVS),” which is used to reimburse facilities’ capital costs, as specified in Section 52505. As specified under W&I Code Section 14126.023(f) the Capital Cost Category shall be based on a FRVS that recognizes the value of the capital related assets necessary to care for Medi-Cal residents. The FRVS is based on a formula developed by the Department that incorporates: the age of the facility, costs incurred, and the fair rental value. A FRVS methodological approach is commonly understood by the long-term care stakeholders and is used to determine a facility’s value and reimbursement rates.

Subsection (m) (originally (t)) is proposed to be adopted to define a “Freestanding Nursing Facility Level-B (FS/NF-B),” as one of the primary facility types subject to the regulatory provisions proposed within Sections 52100 through 52104 and 52500 through 52600 pertaining to the QAF and the facility-specific rate-setting system. A FS/NF-B is commonly understood by the long-term care stakeholders as a licensed and certified skilled nursing facility that is a stand alone facility, not a distinct part of a general acute care hospital as designated in W&I Code Section 14091.21(b), defined in Title 22, CCR, Section 51121 and described in Title 22, CCR Section 51215.

Subsection (n) (originally (u)) is proposed to be adopted to define a “Freestanding Subacute Nursing Facility (FSSA/NF-B),” as one of the primary facility types subject to the regulatory provisions proposed within Sections 52100 through 52104 and 52500 through 52600 pertaining to the QAF and the facility-specific rate-setting system. A FSSA/NF-B is commonly understood by the long-term care stakeholders as a licensed and certified skilled nursing facility that is a stand alone facility, not a distinct part of a general acute care hospital and offers a subacute level of care, as defined in Title 22, CCR, Section 51124.5.

Subsection (v) as originally adopted July 22, 2010 to define “Independent Living Services,” was repealed through the re-adoption of the emergency regulations on January 18, 2011. This repeal was necessary to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 1324.20(c), which eliminated the QAF exemption for an MLRC.

Subsection (o) (originally (w)) is proposed to be adopted to define “Indirect Care Agency Costs” as specified in Section 52502. Through practical experience and consultation with long-term care stakeholders it was determined there were additional costs needed under the facility-specific rate methodology. These costs were categorized as “Indirect Care Agency Costs.” The term “Indirect Care Agency Costs” and the items included in this cost category are commonly understood in the long-term care community.

Subsection (p) (originally (x)) is proposed to be adopted to define “Indirect Care Labor Costs” as specified in Section 52502. W&I Code Section 14126.023 establishes the items to be included as indirect care labor costs, which are components of this definition. The term “Indirect Care Labor Costs” and the items that are included in this cost category are commonly understood by the long-term care community.

Subsection (q) (originally (y)) is proposed to be adopted to define “In-Service Education” as specified in Section 52000(i). This definition is consistent with the definition of “In-Service Education Cost Center” from the OSHPD Accounting and Reporting Manual for California Long-Term Care Facilities, Section 3220.2. In-service education expenses are included in determining direct and indirect care non-labor costs for facility-specific rates. The term “in-service education” is commonly used and understood by long-term care stakeholders.

Subsection (r) (originally (z)) is proposed to be adopted to define a “Labor Inflation Index,” as referenced throughout Section 52502. The phrase “labor inflation index” is commonly understood by the long-term care stakeholders as an index factor used to adjust a facility’s direct care labor costs to reflect the impact of inflation. The labor inflation index may be either a regression or progression, depending upon the given rate year, based upon monthly OSHPD direct care labor costs. The intent of this index is to fiscally forecast two years into the future, where costs are multiplied by different factors to inflate prospectively towards a fixed date in the future, in order to adjust a facility’s direct care labor costs in relation to inflation. In review of a 45-Day public comment pertaining to the clarity of this definition, an alternative definition was developed and proposed through the 15-Day Public Availability published on February 17, 2011. This new definition more accurately reflects the variables and method used to develop this index, based upon the “Study to Develop Labor Index For Long-Term Care Facilities, 2010-11 Rate Study, Report Number 01-10-01 (August 2010).

Subsection (s) (formerly (w)) was adopted through the re-adoption of the emergency regulations on January 18, 2011 and was further refined through the 15-Day Public Availability (published on February 17, 2011), in order to clearly define “Liability Insurance Costs” as referenced through Section 52507. This definition is consistent with SB 853 (Chapter 717, Statutes 2010), specifically W&I Code Section 14126.023(a)(5)(B), which identifies liability insurance as a cost category. This definition is necessary to be consistent with the definition of liability insurance costs that is contained in the CMS Publication 15-1, Chapter 21, Sections 2160 – 2162.10.

Subsection (t) (originally (aa)) is proposed to be adopted to define “Minor Equipment” as specified in Section 52000(i). This definition is based on the description of the capitalization threshold of such an asset provided under CMS Publication 15-1, Chapter 1 Section 108.1 that pertains to acquisitions and will ensure that the meaning of this term is consistent with the description of similar assets (minor equipment) as used under the Medicare Reimbursement Principles. Defining this term within these regulations to be consistent with the Federal description is necessary because OSHPD defines this term differently. It was necessary to include this definition in terms of the capitalization threshold for differentiation between assets that should be capitalized and are therefore included in the FRVS. Assets that meet this definition are not to be included under the FRVS. Assets that have a historical cost of greater than $5,000 are included under the FRVS. Through the 15-Day Public Availability published on February 17, 2011, an amendment was included to correct a typographical error. The term “and” was replaced with the accurate term “or.”

Subsection (bb) as initially adopted on July 22, 2010 to define “Multi-Level Retirement Community” was repealed through the re-adoption of the emergency regulations on January 18, 2011. This repeal was necessary to be consistent with SB 853 (Chapter 717, Statutes 2010), specifically H&S Code Section 1324.20(c), which eliminated the QAF exemption for an MLRC.

Subsection (u) (originally (cc)) is proposed to be adopted to define a “Peer Group” as specified in proposed Section 52508, where each categorical county peer group is identified. The peer groups were established by the professional consulting company in the context of the development of the facility-specific rate methodology, in accordance with W&I Code Sections 14126.02(c) and 14126.023(b). The consulting company conducted a peer group analysis using a statistical cluster of historical median direct care costs, labor markets and the cost of living as indicative sources. The term “peer group” is commonly used and understood in the long-term care community as geographical grouped counties that share similar characteristics. Counties within the same peer group are subject to the same benchmarks and reimbursement associated with the following costs: administrative, direct-pass through, labor and non-labor.

Subsection (v) (originally (dd)) is proposed to be adopted to define a “Rate Year” in order to specify the time frame for payment of the QAF and the time period used for a facility’s cost reporting. The rate year time period is used for key dates and all deadlines associated with the QAF and the facility-specific rate methodology materials, conditions of eligibility and participation, cost categories and auditing requirements. The term “rate year” is based on W&I Code Section 14126.02(b), is consistent with W&I Code Section 14126.021 and is commonly used and understood in the long-term care community as the period that begins on August 1 and ends on July 31 of the following year.

Subsection (w) (originally (ee)) is proposed to be adopted to define a “Rental Factor” as a component within the FRVS specified within the proposed Capital Costs Category, Section 52505(a). When calculating a facility’s total return value, a facility’s rental factor must be multiplied by the sum of a facility’s estimated land value and the current facility value. Once the rental factor value is determined it is later divided by the actual resident days for the cost reporting period or the occupancy adjusted resident days, whichever has a greater value, in order to calculate the final per diem rate. The rental factor component of the FRVS methodology is based upon the FRVS process outlined in the State Plan Supplement 4 to Attachment 4.19-D, pg. 11, effective date August 1,

2005. The phrase “rental factor” is commonly used and understood in the long-term care community as a significant component within the FRVS calculation.

Subsection (x) (originally (ff)) is proposed to be adopted to define a “Replacement Project,” as specified in Section 52505(c), in order to determine the costs incurred while calculating the FRVS under the Capital Costs Category. For replacement projects that are greater than or equal to $500 per-bed, the costs incurred on such projects will be converted into an equivalent number of new beds. The value determined, by combining the new beds with the average age of the old beds, shall be used in computation of the facility’s age. Through the 15-Day Public Availability published on February 17, 2011, an amendment was included based on review of a public comment pertaining to the clarity of this definition. A more comprehensive and commonly understood definition has been developed that was based upon consultation between the Department and the professional consulting company, which resulted in the “Capital Supplement Schedule, Frequently Asked Questions, 2008-09,” which is accessible at http://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629/2008%2009%20Capital%20Sup%20Sch%20FAQ.pdf. The phrase “replacement project” is commonly understood in the Medi-Cal provider community as an asset that fills the place of another asset that is no longer usable.

Subsection (gg) as initially adopted on July 22, 2010 to define “Residential Care Facility for the Elderly,” was repealed through the re-adoption of the emergency regulations, effective on January 18, 2011. This repeal was necessary to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically H&S Code Section 1324.20(c), which eliminated the QAF exemption for an MLRC.

Quality Assurance Fee Program – Sections 52100, 52101, 52102, 52103 and 52104

The authority for the QAF Program was added by AB 1629 (Statutes of 2004, Chapter 875). H&S Code Sections 1324.20 through 1324.30 authorize the Department to implement a QAF Program for FS/NF-Bs and FSSA/NF-Bs. The purpose of the QAF Program is to provide additional reimbursement for, and to support quality improvement efforts in, licensed skilled nursing facilities. State law authorizes the Department to use the funds from collection of the QAFs to enhance federal financial participation in the Medi-Cal program. The CMS approved the Department’s waiver request to implement the QAF Program. The following proposed sections specify the Department’s QAF Program.

Adopt Section 52100. Quality Assurance Fee.

The proposed adoption of Title 22, CCR Section 52100 is necessary to specify which types of skilled nursing facilities will pay the QAF to the Department and how the QAF is determined pursuant to H&S Code Section 1324.21.

Proposed subsection (a) establishes FS/NF-Bs and FSSA/NF-Bs as the skilled nursing facilities subject to payment of the QAF and specifies, for further clarity, that proposed

Sections 52100 through 52104 are the sections that describe the QAF. The cross reference to H&S Code Section 1324.21 is included to provide clear direction to the statute, which specifies that any FS/NF-Bs and FSSA/NF-Bs licensed under H&S Code Section 1250(c) will pay a uniform QAF per resident day. Proposed subsection (a) clarifies that facilities pay the QAF each rate year, as opposed to state fiscal year, since the effective date of the QAF was August 1, 2004. Proposed subsection (a) also specifies that the QAF will not exceed the percentage set forth in Title 42, United States Code (USC), Section 1396b(w)(4)(C)(ii). The cross reference to Title 42, USC, Section 1396b(w)(4)(C)(ii) is included for convenience and to provide clear direction to the federal statute that establishes the percentage limitation which the Department cannot exceed when calculating the QAF.

Proposed subsection (b) describes how the amount due for the facility is calculated so the facility will know how to determine the amount due to the Department. The cross reference to H&S Code Section 1324.21(b) is included for convenience and to provide clear direction to the statute that specifies the requirements used when determining the QAF. Through the re-adoption of the emergency regulations effective on January 18, 2011 a correction was included that changed the word "quarter" to "month," which is consistent with the monthly payment requirement under H&S Code Section 1324.22.

Adopt Section 52101. Payment of the Quality Assurance Fee.

The proposed adoption of Title 22, CCR Section 52101 is necessary to make specific the requirements and processes that pertain to payment of the amount due to the Department, pursuant to H&S Code Section 1324.22.

Proposed subsection (a) incorporates by reference, the Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility Level-B (FSSA/NF-B) Quality Assurance Fee Payment Invoice form, DHCS 9116 (Rev. 03-10), hereinafter referred to as DHCS 9116 (Rev. 03-10). The components of the DHCS 9116 (Rev. 03-10), are explained in detail below. The DHCS 9116 (Rev. 03-10), is incorporated by reference because it would be too cumbersome to publish it directly in the CCR. The DHCS 9116 (Rev. 03-10) is available upon request to the Department through the QAF Unit, Mail Stop 4720, P.O. Box 997425, Sacramento, CA 95899-7425. The DHCS 9116 (Rev. 03-10) is also available online at:
http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Proposed subsection (a) states that each facility is required to submit the DHCS 9116 (Rev. 03-10) with payment of the amount due, to the Department on a monthly basis. Payment of the amount due is due on or before the last day of the month following the month in which the QAF is imposed. Proposed subsection (a) is necessary to inform the facility of its monthly payment requirement as authorized in H&S Code Section 1324.22(a).

Because the QAF is assessed quarterly and a facility is required to remit payment of the amount due on a monthly basis, (in accordance with H&S Code Sections 1324.22(a) and (b)) the Department mails three copies of the DHCS 9116 (Rev. 03-10), on a quarterly basis to each facility for submission of payment of the amount due monthly. This monthly submission satisfies a facility's quarterly and annual reporting requirements pursuant to H&S Code Sections 1324.22(b) and (c).

Proposed subsection (b) states that the Department will issue a delinquency notice to the facility if payment of the amount due is not received within 60 calendar days of the due date specified on the DHCS 9116 (Rev 03-10). Pursuant to H&S Code Section 1324.22(e), action can only be taken against a facility for non-payment after the issuance of a delinquency notice and 60 days past the payment due date. For clarity, subsection (b) specifically states that the delinquency notice will be issued after the 60 day period, so the notice will be issued on or after the 61st day past the due date, and payment is due within 15 calendar days of the date of the delinquency notice. Proposed subsection (b) is necessary to give notice to the facility of the outstanding amount and to allow opportunity to arrange for payment of the amount due.

Proposed subsection (c) specifies that, beginning on the 61st calendar day from the date the payment is due, the facility will be liable for payment of interest at the rate of seven percent per annum on any unpaid amount due, until the unpaid amount due, plus any interest, is paid in full. Proposed subsection (c) is necessary to inform the facility of the amount of interest that will be assessed and when the interest will begin to accrue for any unpaid amount due. This amount of interest is authorized by Article XV, Section 1 of the California Constitution and Civil Code Sections 3281 and 3287.

Proposed subsection (d) outlines the methods of recovery for any outstanding amount due, plus interest, owed by the facility to the Department. Proposed subsection (d)(1) authorizes the Department to offset any Medi-Cal reimbursement payments due to the facility. Proposed subsection (d)(2) provides for the execution of a repayment agreement. A repayment agreement is an agreement between the facility and the Department, which allows the facility to repay the outstanding amount owed over a period of time specified by the Department. Through the re-adoption of the emergency regulations effective on January 18, 2011, to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically H&S Code Section 1324.22(h)(1), subsection (d)(3) was amended to authorize the Department to assess a penalty up to 50 percent of the unpaid amount due. Proposed subsection (d)(4) notifies the facility that the Department can recommend to the California Department of Public Health that license renewal be delayed until the Department has recovered the full amount due. Proposed subsection (d) is necessary to inform the facility of the actions the Department may take if all or any part of the amount due remains unpaid. Authority for the proposed recovery methods in subsection (d) is provided in H&S Code Sections 1324.22(e) and (f).

Proposed subsection (e), was amended through the re-adoption of the emergency regulations effective on January 18, 2011, to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically H&S Code Sections 1324.29(b) and (c). This subsection specifies that the facility is liable for any payments to the Department for QAFs assessed prior to July 31, 2012, but not yet collected. The QAF shall cease to be assessed on or after July 31, 2012 in accordance with H&S Code Section 1324.29. However, subsection (e) is necessary to specify that a facility is responsible to pay a previously assessed QAF even after the assessment of the QAF ceases on July 31, 2012.

Components of the form DHCS 9116 (Rev. 03-10) in proposed Section 52101(a).

The State of California—Health and Human Services Agency, Department of Health Care Services issues DHCS 9116 (Rev. 03-10) which is incorporated by reference in proposed Section 52101(a).

The Department mails three copies of the DHCS 9116 (Rev. 03-10) on a quarterly basis to each facility. The facility shall remit payment monthly, on or before the last day of the month following the month in which the QAF is imposed, to the Department with a completed DHCS 9116 (Rev. 03-10). Monthly submission of the completed DHCS 9116 (Rev. 03-10) with payment shall satisfy the facility's monthly payment requirement as specified in H&S Code Section 1324.22(a). This monthly submission also satisfies a facility's quarterly and annual reporting requirements pursuant to H&S Code Sections 1324.22(b) and (c).

Within the DHCS 9116 (Rev. 03-10), there are "FREE TEXT" areas completed by the Department prior to being mailed to the facility. If a facility elects to use the DHCS 9116 (Rev. 03-10) from the website, it is the facility's responsibility to complete the "FREE TEXT" fields.

DHCS 9116 (Rev. 03-10) includes "FREE TEXT" areas within the title that represent the current fiscal year and the dates for the start and end of the corresponding quarter. This is necessary to identify the month and year for which the QAF is being imposed.

DHCS 9116 (Rev. 03-10) includes the Department's address. This is necessary since the facility is required to remit payment, along with the completed DHCS 9116 (Rev. 03-10), to the Department at the following address:

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

DHCS 9116 (Rev. 03-10) includes "FREE TEXT" areas for the name, address, city, state, and zip code of the facility. This information is necessary in order for the Department to identify which facility is submitting the invoice and payment.

DHCS 9116 (Rev. 03-10) includes an area for the facility's Office of Statewide Health Planning and Development Number and the National Provider Identifier (NPI). The facility provides this information in order for the Department to identify which facility is submitting the invoice and payment.

DHCS 9116 (Rev. 03-10) includes a “FREE TEXT” area for the date the invoice and QAF payment is due. The Due Date is necessary to inform the facility of when the QAF payment must be remitted to the Department. The QAF payment is due on or before the last day of the month following the month in which the QAF is imposed.

DHCS 9116 (Rev. 03-10) includes an area for the facility to enter the Amount Remitted. This is necessary in order for the Department to identify how much money the facility actually paid versus how much is owed.

DHCS 9116 (Rev. 03-10) contains a section for accounting code information including the Index, Object Detail, Agency Object, BLK, Source, Agency Source, PCA, FFY, and Fund. The FFY is “FREE TEXT” and will be provided by the Department. FFY stands for Federal Fiscal Year. This information is necessary for the Department to process the facility’s payment.

DHCS 9116 (Rev. 03-10) provides spaces in which the facility enters the Total Resident Days. This information is necessary to calculate the Amount Due as explained below.

DHCS 9116 (Rev. 03-10) includes a “FREE TEXT” area for the Fee Amount. The Fee Amount is a dollar figure, which has been calculated by the Benefits, Waivers, Analysis, and Rates Division of the Department for the current rate year. This information will be provided by the Department and is necessary to calculate the Amount Due as explained below.

DHCS 9116 (Rev. 03-10) provides spaces in which the facility enters the Amount Due. This information is necessary to specify how much money is owed by the facility to the Department.

DHCS 9116 (Rev. 03-10) provides a space in which the facility enters Original Signature, Date, Printed Name, Phone Number, and E-Mail address. The original signature is needed to demonstrate who completed the DHCS 9116 (Rev. 03-10) and the date is necessary to establish when the DHCS 9116 (Rev. 03-10) was completed. The printed name is necessary so the person can be clearly identified, and the phone number and e-mail address are necessary for contact purposes.

DHCS 9116 (Rev. 03-10) instructs the facility in bold lettering to submit the entire payment invoice without cutting the page in half. This is necessary for departmental scanning purposes.

The section of the DHCS 9116 (Rev. 03-10) entitled “Payment Invoice Instructions,” further details the information requested above. These instructions are necessary to assist the facility with correctly completing the payment invoice.

Total Resident Days is described as the facility's total resident days for the month listed on the DHCS 9116 (Rev. 03-10). Resident Days are the number of days in which a resident resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice. This information is required on a quarterly basis pursuant to H&S Code Section 1324.22(b) and is captured through the monthly accumulation of resident days. This description is necessary for the facility to correctly determine the Total Resident Days needed to calculate the Amount Due from the facility. The facility is instructed to enter the Total Resident Days in the space provided.

Amount Due is described as the facility's Total Resident Days multiplied by the Fee Amount as provided on the payment invoice by the Department. The facility needs to calculate this amount in order to comply with H&S Code Section 1324.22(a). The facility is instructed to enter the Amount Due in the space provided.

Amount Remitted is described as the amount of the check or money order that is being sent with the DHCS 9116 (Rev. 03-10). The facility is instructed that the Amount Remitted should be the same as the Amount Due and to enter the Amount Remitted in the space provided.

The instructions for the Original Signature require a signature, in ink, in the space provided.

The instructions for the Date require entry of the date the DHCS 9116 (Rev. 03-10) was completed.

The instructions for the Phone Number/E-Mail require entry of an area code, daytime phone number and email address in the space provided.

Under these payment invoice instructions, the facility is directed to the following website where payment invoices are available:
http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

The last paragraph instructs the facility to submit the completed DHCS 9116 (Rev. 03-10) along with the payment to the Department's address listed above. The facility is also instructed to include the NPI on the check or money order in order to expedite the payment process. The facility is informed that payments are due by the due date indicated above and that failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal. The instructions are necessary to promote the timely submission of invoices and payments to the Department that are complete, accurate and easily identifiable. In addition, these instructions clearly specify the consequences of not remitting the amount due in a timely manner.

Adopt Section 52102. Exemption from the Quality Assurance Fee.

The proposed adoption of Title 22, CCR Section 52102 is necessary to specify what facilities are exempt from payment of the QAF.

Section 52102 was amended through the re-adoption of the emergency regulations effective on January 18, 2011, to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically the cross reference to the H&S Code was amended to Section 1324.20(c), which defines an “exempt facility,” which is a facility that is not subject to the QAF. In addition to this cross reference, this section also references Section 52101, which outlines the payment process for the QAF. The cross references are included to provide clear direction to the related statute and regulation and to conveniently locate the provisions that describe what facilities are exempt from payment of the QAF. Facilities that are not specified under this section shall be subject to the QAF.

Also through the re-adoption of the emergency regulations, subsections (b) and (c) were repealed to be consistent with H&S Code Section 1324.20(c), which eliminated the QAF exemption for an MLRC. Subsequently, the designation “subsection (a)” was removed.

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

Through the re-adoption of the emergency regulations effective on January 18, 2011, this section was repealed to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically with H&S Code Sections 1324.20(c) and 1324.21(a), which eliminated the QAF exemption for an MLRC.

Adopt Section 52104. Change of Ownership.

The proposed adoption of Title 22, CCR Section 52104 is necessary to clarify that the QAF is assessed on the facility, and not the owner(s).

Proposed Section 52104 establishes that payment of the amount due, plus interest, owed by the facility stays with the facility in any change of ownership. This section reduces the confusion over debt responsibility between buyers and sellers in change of ownership transactions and is in accordance with H&S Code Section 1324.22(f).

Medi-Cal Long Term Care Reimbursement – Sections 52500, 52501, 52502, 52503, 52504, 52505, 52506, 52507, 52508, 52509, 52510, 52511, 52512, 52513, 52514, 52515 and 52516

The authority for the Medi-Cal LTC Reimbursement Act was added by AB 1629 (Statutes of 2004, Chapter 875). W&I Code Sections 14126 through 14126.035 authorize the Department to implement a facility-specific rate-setting system. The Department contracted with professional consulting services and worked in collaboration with long-term care stakeholders in the development and implementation of the facility-specific rate-setting system. CMS approved the Department's facility-specific rate-setting system by approving the Supplement 4 to Attachment 4.19-D of the California State Plan. The following proposed sections specify the Department's facility-specific rate-setting system.

In addition, Senate Bill (SB) 853 (Chapter 717, Statutes of 2010) extended the QAF Program and the Medi-Cal LTC Reimbursement Act until July 31, 2012, revising and implementing changes to the rate reimbursement methodology, quality assurance fee program and the new quality and accountability payment system. These changes were reflected in the re-adoption of the regulations effective January 18, 2011 (OAL File # 2010-1231-01EE) and through the 15-Day Public Availability published on February 17, 2011.

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

The proposed adoption of Title 22, CCR Section 52500 is necessary to specify what facilities are subject to the facility-specific rate-setting system, as set forth through W&I Code Sections 14126 through 14126.035.

Proposed subsection (a) identifies FS/NF-B, and FSSA/NF-B as the facilities that are subject to the facility-specific rate-setting system that is authorized through W&I Code Section 14126, which names the Medi-Cal Long-Term Care Reimbursement Act. W&I Code Section 14126.02(b) specifically references the type of facility to which this rate-setting system shall apply and includes a cross reference to H&S Code Section 1250(c), which defines a "skilled nursing facility." In addition, W&I Code Section 14126.021 indicates this rate-setting methodology is specific to "free standing nursing facilities." Proposed subsection (a) also specifies, for further clarity that proposed Sections 52500 through 52516 are the sections that describe the facility-specific rate-setting system also referred to as the reimbursement methodology.

Proposed subsection (b) establishes that each facility-specific per diem rate will be calculated prospectively, using audited cost report data. The data is calculated prospectively in order to use the most recent cost reporting data. The cost reporting data must be in accordance with the OSHPD submission dates. This data is then subject to auditing requirements prescribed by the Department. The cross reference to H&S Code Section 128730 is included to provide clear direction to the statute that specifies the facility-specific data requirements necessary for the calculation of the facility-specific rates and to conveniently locate this relevant statutory provision within the regulation. Subsection (b) was amended through the re-adoption of the emergency regulations effective on January 18, 2011, to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(i). The term "audited" was added and the last phrase was removed.

Proposed subsection (b)(1) specifies that cost report data must be submitted to OSHPD in accordance with Title 22, CCR Section 97040 and includes a cross reference to this section to provide a correlation to this regulatory requirement and conveniently locate the provisions that set forth cost report data submission requirements. Facilities currently submit cost report data to OSHPD on an annual basis to receive reimbursement. The adoption of this subsection simply solidifies this existing data submission process that falls under the facility-specific rate-setting system in a central location (the Department's regulations).

Proposed subsection (b)(2) specifies that cost report data audited by the Department is used for facility-specific rate-setting. This cost report data is obtained by the Department, through the process outlined under subsections (b) and (b)(1) and is necessary to establish the facility-specific rates that are required under the Medi-Cal LTC Reimbursement Act. In accordance with Title 22, CCR Section 97040 and W&I Code Section 14126.023(i), only data which has been audited by the Department shall be used for the computation of reimbursement rates.

Adopt Section 52501. Facility-Specific Rate Methodology.

The adoption of Title 22, CCR Section 52501 was initially proposed to identify the cost components associated with the facility-specific cost-based per diem payment required by and based upon provisions under W&I Code Section 14126.023. Each cost category contains a range of costs. In accordance with W&I Code Section 14126.023(b)(2) costs within a specific cost category could not be shifted to another cost category. Maintaining these costs within the specific cost category ensures there is no overlap of the costs that are utilized in the facility-specific rate-setting methodology. Section 52501 includes a sentence that leads into the listing of the major cost categories that are described in subsections (a) through (f) below. This section was amended through the re-adoption of the emergency regulations effective on January 18, 2011, to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(a)(5)(B) and included the addition of subsection (f) "Professional liability insurance costs."

The regulatory provisions established under Section 52501, as well as under the subsequent regulation sections that pertain to the LTC rate methodology, have been developed in accordance with the Medi-Cal LTC Reimbursement Act (W&I Code Sections 14126 through 14126.035).

Proposed subsection (a) identifies the "Labor Costs" Category as specified under W&I Code Section 14126.023(a)(1). Proposed Sections 52000 (h) and (p), which define direct care labor costs and indirect care labor costs, break this cost category down further as indicated under W&I Code Sections 14126.023(d) and (e). The reason for these definitions can be found above in the definitions portion of this statement of reasons.

Proposed subsection (b) identifies the "Direct and Indirect Care Non-labor Costs," which is also defined under Section 52000(i). The reason for this definition can be found above in the definitions portion of this statement of reasons. Indirect care non-labor costs are specified as a cost component under W&I Code Section 14126.023(a)(2).

Direct care non-labor costs are not a component from the W&I Code but have been included under this cost category based on practical experience and consultation with long-term care stakeholders. This consultation revealed that this cost component is considered part of this cost category, which represents all costs other than labor that are necessary in the provision of long-term care services. Including “direct care non-labor” provides clarification that all other costs included on the cost report (with the exception of administration) belong in this cost component.

Proposed subsection (c) identifies the “Administrative costs” Category, as specified under W&I Code Section 14126.023(a)(3) and defined under proposed Section 52000(b). The reason for this definition can be found above in the definitions portion of this statement of reasons.

Proposed subsection (d) identifies the “Capital costs” Category as specified under W&I Code Section 14126.023(a)(4) and defined under proposed Section 52000(e). The reason for this definition can be found above in the definitions portion of this statement of reasons. The Capital Costs Category is based on the FRVS, as defined under proposed Section 52000(l) and described under proposed Section 52505 and the corresponding portion of this statement of reasons.

Proposed subsection (e) identifies the “Direct pass-through costs” Category as specified under W&I Code Section 14126.023(a)(5). Proposed Sections 52000(j) and (k) break this cost category down further, as indicated under W&I Code Section 14126.023(a)(5) and define “direct pass-through costs for care giver training,” and “direct pass-through costs for facility license fees.” The reasons for these definitions can be found above in the definitions portion of this statement of reasons. These direct pass-through costs are discussed further under Section 52506(a)(1).

Subsection (f), as proposed through the re-adoption, identifies the “Professional liability insurance costs” Category, as specified under W&I Code Section 14126.023(a)(5)(B) and defined under proposed Section 52000(s). The reason for this definition can be found above in the definitions portion of this statement of reasons.

Adopt Section 52502. Labor Costs Category.

The proposed adoption of Title 22, CCR Section 52502 is necessary to describe how the Labor Costs Category portion of the rate will be calculated and what data will be used.

Proposed subsection (a) specifies the four components that make up the Labor Costs Category under the facility-specific cost-based per diem payment. These components are individually defined in Section 52000 and described under the corresponding section of the statement of reasons. The direct and indirect care labor costs are based upon the provisions pertaining to labor costs under W&I Code Section 14126.023(a)(1), and are further described under Section 52501(a), referenced above. Direct and indirect care agency costs were not specifically included as cost components under W&I

Code Section 14126.023(a), but were included as part of the Labor Costs Category after the initial implementation of this methodology based on long-term care industry requirements. The inclusion of these “agency costs” both direct (as defined under Section 52000(g)) and indirect (as defined under Section 52000(o)) within the Labor Costs Category is necessary in those instances when a facility hires an outside contractor to provide “agency” services for an entire department within the facility. In these instances, the contract cost includes labor and other costs for operating the department. It is necessary to break out the labor portion of the contract for inclusion in the Labor Costs Category from the non-labor costs, which would apply under the other Non-Labor Costs Category.

The inclusion of labor costs as part of the rate methodology is also the result of discussion and collaboration between the Department and long-term care stakeholders regarding quality resident outcomes. It has been determined that there is a direct correlation between the quality of care provided to residents and the skill, experience, and longevity of health care providers. The inclusion of the Labor Costs Category in the rate methodology lends to the delivery of quality of care based on a facility’s ability to hire and retain qualified health care providers through the provision of desirable wages.

In addition, as a result of SB 853 (Chapter 717, Statutes of 2010) the Labor Driven Operating Allocation (LDOA) component of the facility-specific reimbursement methodology was removed from this subsection through the re-adoption of the emergency regulations on January 18, 2011.

Proposed subsection (b) simply describes the basic calculation for the direct care labor costs per diem, which is part of the rate calculation. Consistent with W&I Code Sections 14126.023(b)(2) and (d)(1), the two types of direct care costs (labor and agency) are added and then divided by the total resident days, yielding the cost per diem.

Proposed subsection (b)(1) initially specified that the benchmark for each daily direct care labor cost payment was at the 90th percentile of each peer group, which is included under the calculation of direct care labor costs, subsection (b), to be consistent with W&I Code Section 14126.023(d)(1). Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended based on comments received during the 45-Day Public Comment Period, as follows: 1) “each” was changed to “the” for clarity and to ensure that benchmarks are applied only to the rate component and not to the individual component within the cost category; and 2) “payment” was changed to “rate component” to more accurately describe how benchmarks apply to each cost component.

Proposed subsection (b)(2) initially specified that reimbursement was the lower of either the actual cost or the benchmark for the facility’s peer group. The benchmarks within W&I Code Section 14126.023 are designed for cost control. However, if a facility’s actual inflated costs fall below that benchmark, the facility will be reimbursed at their actual inflated costs because facilities cannot be reimbursed for costs they did not incur. Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended based on comments received during the 45-Day Public Comment Period, as follows: 1) “reimburse” was replaced with “determine the rate component for” to be consistent with subsection (b)(1) – see above; and 2) “inflated” was included to ensure that the rate component is computed accurately.

Proposed subsection (b)(3) was removed through the 15-Day Public Availability, published on February 17, 2011, based on a comment received during the 45-Day Public Comment Period. The definition of “Labor Inflation Index,” under Section 52000(r), was revised through the 15-Day Public Availability to more accurately reflect the variables and methods used to develop this index, based upon the “Study to Develop Labor Index For Long-Term Care Facilities, 2010-11 Rate Study, Report Number 01-10-01 (August 2010). Thus this subsection was no longer necessary.

Proposed subsection (b)(3), (originally (b)(4)), describes how a facility’s direct care labor costs will be adjusted, using the labor inflation index, as defined in Section 52000(r). As a result of collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders, direct care costs are adjusted from the mid-point of the cost reporting period (calendar year) to the mid-point of the current rate year (fiscal year for which the facilities are currently applying for reimbursement) in order to reflect the impact of inflation (given that the cost reporting period took place a significant amount of time in the past, in relation to the reimbursement that facilities will receive for the current rate year).

Proposed subsection (b)(4), (originally (b)(5)), describes the situation that may exist when a FSSA/NF-B has service agreements with unrelated contractors to provide physical therapy, speech pathology, occupational therapy or respiratory therapy. The costs for these therapies are included in the FSSA/NF-B daily rate in accordance with Title 22, CCR Sections 51511 and 51511.5. Because these therapies are included in the daily rate, the labor portion of providing these therapies is included in the Direct Care Labor Category of cost determination (as direct care agency costs). The contracts for these services usually include a contract rate that includes both labor and other non-labor costs. Only the labor portion of the contract services should be included in this portion of the rate calculation. During the implementation of this methodology it was found that at times, the contracts did not specify the break down of contract costs between labor and non-labor. When the labor portion of the contract is not specified and no documentation is given to the Department, the entire contract cost is considered other non-labor and not to be included in this cost category. In order to ensure against reimbursing facilities for costs they did not incur, this cost control practice is used since the Labor Cost Category benchmark is set at the 90th percentile, while the other non-labor cost category benchmark is set at the 75th percentile. When these services are provided by a related entity, it is only necessary to include the cost of the contract as if the service was provided at the facility. When a related party transaction exists, the cost allowed by the related organization cannot be more than what this organization would have paid in the outside market. This eliminates any profit factor the related organization charges the facility. This portion of the rate methodology is consistent with CMS Publication 15-1, Chapter 10 Section 1005 and is commonly understood by long-term care stakeholders.

Proposed subsection (c) simply describes the basic calculation for the indirect care labor costs per diem, which is part of the rate calculation. Consistent with W&I Code Sections 14126.023(b)(2) and (d)(2), the two types of indirect care costs (labor and agency) are added and then divided by the total resident days, yielding the cost per diem.

Proposed subsection (c)(1) describes the situation that may exist if a facility employs a contractor to provide staff to operate a department within the facility. The costs for this outside (temporary) labor is considered "agency" costs as described under subsection (a) above. In order to distinguish these particular costs, facilities must provide the Department with either a portion of the contract agreement or other documentation that clearly distinguishes the division between labor and non-labor costs, which is necessary for the accurate placement of costs under the appropriate cost category and is consistent with W&I Code Section 14126.023(b)(2). If a facility fails to provide the documentation necessary to distinguish this division of indirect care labor and non-labor costs, then these contractor costs are based on an average percentage for each facility department. These percentages, as specified under subparagraphs (A) through (D), are the result of consideration of long-term care industry standards and collaboration between the Department and long-term care stakeholders. In order to get a more accurate industry average of the actual costs, the audited cost data for all the facilities that did not employ a contractor were used to develop a cost center average break out between labor and non-labor.

Proposed subsection (c)(2) initially specified that the benchmark for each daily indirect care labor cost payment was at the 90th percentile of each peer group, which is included under the calculation of indirect care labor costs, subsection (c), to be consistent with W&I Code Section 14126.023(d)(2). Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended based on comments received during the 45-Day Public Comment Period, as follows: 1) "each" was changed to "the" for clarity and to ensure that benchmarks are applied only to the rate component and not to the individual component within the cost category; and 2) "payment" was changed to "rate component" to more accurately describe how benchmarks apply to each cost component.

Proposed subsection (c)(3) initially specified that reimbursement was the lower of either the actual cost or the benchmark for the facility's peer group. The benchmarks within W&I Code Section 14126.023 are designed for cost control. However, if a facility's actual inflated costs fall below that benchmark, the facility will be reimbursed at their actual inflated costs because facilities cannot be reimbursed for costs they did not incur. Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended based on comments received during the 45-Day Public Comment Period, as follows: 1) "reimburse" was replaced with "determine the rate component for" to be consistent with subsection (b)(1) – see above; and 2) "inflated" was included to ensure that the rate component is computed accurately.

Proposed subsection (c)(4) was removed through the 15-Day Public Availability, published on February 17, 2011, based on a comment received during the 45-Day Public Comment Period. The definition of "Labor Inflation Index," under Section 52000(r),was revised through the 15-Day Public Availability to more accurately reflect the variables and methods used to develop this index, based upon the "Study to Develop Labor Index For Long Term Care Facilities, 2010-11 Rate Study, Report Number 01-10-01 (August 2010). Thus this subsection was no longer necessary.

Proposed subsection (c)(4), (originally (c)(5)) describes how a facility's indirect care labor costs will be adjusted, using a labor inflation index as defined in Section 52000(r). As the result of collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders, indirect care costs are adjusted from the mid-point of the cost reporting period (calendar year) to the mid-point of the current rate year (fiscal year for which the facilities are currently applying for reimbursement) in order to reflect the impact of inflation (given the cost reporting period took place a significant amount of time in the past, in relation to the reimbursement that facilities will receive for the current rate year).

Proposed subsection (d) was removed through the re-adoption of the emergency regulations on January 18, 2011, in accordance with SB 853 (Chapter 717, Statutes of 2010), specifically to be consistent with W&I Code Section 14126.023(e), the removal of the LDOA from the Labor Costs Category.

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

The proposed adoption of Title 22, CCR Section 52503 is necessary to describe how the Direct and Indirect Care Non-Labor Costs Category portion of the rate will be calculated and what data will be used.

The initial paragraph under Section 52503 simply describes the basic calculation for the direct and indirect care non-labor costs per diem, which is part of the rate calculation. Indirect care non-labor costs are specified as a cost category under W&I Code Section 14126.023(a)(2). Direct care non-labor costs were not identified in the W&I Code, but have been included under this cost category based on practical experience and consultation with long-term care stakeholders. It was determined that this cost component is considered part of this cost category, which represents all costs other than labor that are necessary in the provision of long-term care services. Consistent with W&I Code Section 14126.023(b)(2), the costs under this category are divided by the total resident days, yielding the cost per diem. Through the re-adoption of the emergency regulations on January 18, 2011 and through the 15-Day Public Availability, published on February 17, 2011, the word "care" was added, since it was inadvertently omitted in the original filing. Sections 52000(i) and 52501(b) both identify the correct use of the phrase "direct and indirect care non-labor costs," this change makes Section 52503 consistent with these other sections.

Proposed subsection (a) initially specified that the benchmark for each daily direct and indirect care non-labor cost payment was at the 75^{th} percentile of each peer group, which is included under the calculation of direct and indirect care non-labor costs, specified under this section, to be consistent with W&I Code Section 14126.023(a)(2). This will be the benchmark on each facility's cost. The benchmarks within W&I Code Section 14126.023 are designed for cost control. However, if a facility's actual costs fall below that benchmark, the facility will be reimbursed for actual costs because a facility cannot be reimbursed for costs not incurred. Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended based on a comment received during the 45-Day Public Comment Period, as follows: 1) "each" was changed to "the" for clarity and to ensure that benchmarks are applied only to the rate component and not to the individual component within the cost category; and 2) "payment" was changed to "rate component" to more accurately describe how benchmarks apply to each cost component.

Proposed subsection (b) initially specified that reimbursement was the lower of either the actual cost or the benchmark for the facility's peer group. The benchmarks within W&I Code Section 14126.023 are designed for cost control. However, if a facility's actual inflated costs fall below that benchmark, the facility will be reimbursed for actual inflated costs because a facility cannot be reimbursed for costs not incurred. Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended based on comments received during the 45-Day Public Comment Period, as follows: 1) "reimburse" was replaced with "determine the rate component for" to be consistent with Section 52502(b)(1) – see above; and 2) "inflated" was included to ensure that the rate component is computed accurately.

Proposed subsection (c) describes how a facility's direct and indirect care non-labor costs will be adjusted, using the California CPI, which is established annually by the Department of Industrial Relations, and described above. The California CPI is used as the inflation index for these non-labor costs because it is an applicable index developed on an annual basis, while taking into consideration all inflation adjustments and values for allowable non-labor costs. In this case the Department does not have to establish a new inflation index as is necessary for some of the other cost categories. As the result of collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders, direct and indirect care non-labor costs are adjusted from the mid-point of the cost reporting period (calendar year) to the mid-point of the current rate year (fiscal year for which the facilities are currently applying for reimbursement, not based on a standard calendar year) in order to reflect the impact of inflation (given that the cost reporting period took place a significant amount of time in the past, in relation to the reimbursement that facilities will receive for the current rate year).

Adopt Section 52504. Administrative Costs Category.

The proposed adoption of Title 22, CCR Section 52504 is necessary to describe how the Administrative Costs Category portion of the rate will be calculated and what data will be used.

Further specifying what is and what is not included in the Administrative Cost Category is intended to clarify portions of the Medi-Cal LTC Reimbursement Act that were silent or unclear. These additions are the result of collaboration between the Department and long-term care stakeholders, over the implementation period of this rate-setting methodology.

The initial paragraph under Section 52504 simply describes the basic calculation for the administrative costs per diem, which is part of the rate calculation. Administrative costs are specified as a cost category under W&I Code Section 14126.023(a)(3). Consistent with W&I Code Section 14126.023(b)(2), the costs under this category are divided by the total resident days, yielding the cost per diem.

Proposed subsection (a) initially specified that the benchmark for each daily administrative cost payment was at the 50^{th} percentile of each peer group, which is included under the calculation of administrative costs, specified under this section, to be consistent with W&I Code Section 14126.023(a)(3). This will be the benchmark on each facility's cost. Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended based on a comment received during the 45-Day Public Comment Period, as follows: 1) "each" was changed to "the" for clarity and to ensure that benchmarks are applied only to the rate component and not to the individual component within the cost category; and 2) "payment" was changed to "rate component" to more accurately describe how benchmarks apply to each cost component.

Proposed subsection (b) initially specified that reimbursement was the lower of either the actual cost or the benchmark for the facility's peer group. The benchmarks within W&I Code Section 14026.023(a) are designed for cost control. However, if a facility's actual inflated costs fall below that benchmark, the facility will be reimbursed for actual inflated costs because a facility cannot be reimbursed for costs not incurred. Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended based on comments received during the 45-Day Public Comment Period, as follows: 1) "reimburse" was replaced with "determine the rate component for" to be consistent with Section 52502 (b)(1) – see above; and 2) "inflated" was included to ensure that the rate component is computed accurately.

Proposed subsection (c) describes how a facility's administrative costs will be adjusted, using the California CPI, which is described above. The California CPI is used as the inflation index for these administrative costs because it is an applicable index developed on an annual basis, while taking into consideration all inflation adjustments and values for allowable administrative costs. In this case the Department does not have to establish a new inflation index as is necessary for some of the other cost categories. As the result of collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders, administrative costs are adjusted from the mid-point of the cost reporting period (calendar year) to the mid-point of the current rate year (fiscal year for which the facilities are currently applying for reimbursement, not based on a standard calendar year) in order to reflect the impact of inflation (given that the cost reporting period took place a significant amount of time in the past, in relation to the reimbursement that facilities will receive for the current rate year).

Proposed subsections (d) through (i) specify the parameters surrounding administrator compensation, which are consistent with provisions from the CMS Publication 15-1, Chapter 9, Sections 900 through 907.1. The CMS Publication 15-1, Chapter 9, Sections 900 through 907.1 pertain to application, definitions, criteria and procedures related to the establishment of reasonable compensation and the determination of the allowance for administrator compensation.

Proposed subsection (d) describes the common types of administrators and provides clear direction to the H&S Code where a skilled nursing facility is defined for clarity and convenience. This subsection also offers a lead in to paragraphs (1) through (4) that outline the limitations for administrator compensation, which are commonly understood by the long-term care stakeholders.

A national survey was conducted over 20 years ago by CMS that was the basis for the establishment of federal reasonable administrator compensation ranges. Each year the results of this survey were updated by the Department using inflation factors published in the CMS Publication 15-1, Chapter 9, Section 905.6. The long-term care stakeholders indicated that the national survey did not adequately reflect administrator compensation within the State of California. This was demonstrated through numerous appeals of nursing facility audits which adjusted compensation based on the national survey. Subsequently, in calendar years 1999 and 2006, and in accordance with the provisions set forth under CMS Publication 15-1, Chapter 9, as described above, the Department conducted administrator compensation surveys for California. In the intervening years between the actual surveys, inflation factors published by CMS Publication 15-1, Chapter 9, Section 905.6 are used to inflate the California Survey, which is consistent with the federal practice of inflating the national survey on an annual basis.

Proposed subsection (d)(1) specifies the limitation of reasonable value for services performed, which is based on CMS Publication 15-1, Chapter 9, Sections 901, 902.3 and 906.3. Facilities place different labels on services performed by administrators. This subsection is necessary to specify that regardless of the label or description placed on a service, all of the compensation will be aggregated to determine reasonableness.

Proposed subsection (d)(2) specifies the limitation for essential compensation to employ someone in place of the administrator for maintenance of daily operations, which is consistent with CMS Publication 15-1, Chapter 9, Section 902.4.

Proposed subsection (d)(3) specifies the limitation of the value of comparable services and the basis for this comparison, which is based on CMS Publication 15-1, Chapter 9, Sections 904, 904.1 and 904.2.

Proposed subsection (d)(4) specifies the limitation that the value of services is determined by arm's length transactions. This is based upon CMS Publication 15-1, Chapter 9, Section 902.3, which states that reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions depending upon the facts and circumstances of each case. Reasonable compensation is limited to the fair market value of services rendered by the owner in connection with resident care. It is the fair market value that determines the compensation be paid at that of an arm's length transaction.

Proposed subsection (e) specifies if an assistant administrator performs administrator duties this will be a factor in the reasonableness determination, which is consistent with CMS Publication 15-1, Chapter 9, Section 904.2 C. 2.

Proposed subsection (f) indicates that full-time compensation will accompany 40 hours per week dedicated to the relevant services and less than 40 hours per week will be compensated on a proportionate basis. This provision is based on CMS Publication 15-1, Chapter 9, Section 904.2 C. 1.

Proposed subsection (g) specifies if an administrator spends less than full time performing services for several facilities, then the allowable compensation will be on a proportionate basis. This provision is based on CMS Publication 15-1, Chapter 9, Section 904.2 D. 1.

Proposed subsection (h) indicates there will be surveys/data collection to determine reasonable administrator compensation in proprietary and non-proprietary facilities in like geographic locations. This provision is based on CMS Publication 15-1, Chapter 9, Section 905.2. The corresponding section for administrator compensation in the State Plan Supplement 4 to Attachment 4.19-D, pg. 4, effective on August 1, 2005, also cross references the CMS Publication 15-1, Chapter 9 and requires the Department's adherence to these CMS standards.

Proposed subsection (h)(1) specifies data collected from non-owner administrators will be used to develop compensation ranges, by geographic location and facility size, as a basis to evaluate administrator compensation during audits and cost adjustments. This provision is consistent with CMS Publication 15-1, Chapter 9, Section 905.2 that pertains to non-owner administrators. The corresponding section for administrator compensation in the State Plan Supplement 4 to Attachment 4.19-D, pg. 4, effective on

August 1, 2005, also cross references the CMS Publication 15-1, Chapter 9 and requires the Department's adherence to these CMS standards.

Proposed subsection (h)(2) indicates compensation ranges are based on "full time" data collected consistent with CMS Publication 13, Part 2 Audits Reimbursements/Program Administration, Section 2120.1 H. Based on a comment received during the 45-Day Public Comment Period, the phrase "and excludes extreme values and other data anomalies," was removed through the 15-Day Public Availability published on February 17, 2011. It was determined this phrase was not necessary and removal will support a more accurate reflection of reasonable compensation.

Proposed subsection (h)(3) specifies ranges will be updated by the CMS inflation factor in years when there is no survey. Taking inflation into consideration is necessary when comparing reported data to survey results to insure proper matching of time and dollars. The use of such a survey is consistent with the inflation factor described under CMS Publication 15-1, Chapter 9, Section 905.6.

Proposed subsection (i) specifies that compensation to a relative of a facility owner is also subject to the provisions of subsection (d). A cross reference to this subsection is provided for convenience. Through the re-adoption of the emergency regulations effective January 18, 2011, this cross reference was corrected from (a) to (d). Relatives are also subject to the provisions of subsection (d) because employees related to the provider are not an arm's length transaction and a review for reasonableness must be made to insure the fair market of the services is allowed as a cost. This subsection also provides a lead in to paragraphs (1) through (6) that list the persons that are considered relatives, which is consistent with the CMS Publication 15-1, Chapter 9, Section 902.5.

Adopt Section 52505. Capital Costs Category.

The proposed adoption of Title 22, CCR Section 52505 is necessary to describe how the Capital Costs Category portion of the rate will be calculated and what information will be used. Through the 15-Day Public Availability, published on February 17, 2011, this section was revised including the removal of some subsections and the amendment of others, to be more detailed with the FRVS calculation as described in the State Plan Supplement 4 to Attachment 4.19-D, pg.'s 9-14, effective August 1, 2005. These amendments were based on comments received during the 45-Day Public Comment Period and consideration of further stakeholder input.

W&I Code Section 14126.023 requires the Capital Costs Category of the facility-specific rate methodology to be based on a FRVS that recognizes the value of capital related assets necessary for the care of Medi-Cal residents. The FRVS component of the facility-specific rate methodology shall be used to reimburse the allowable capital costs determined by the assessment of a facility's base value, incorporating several factors used to determine the value of a space being utilized for Medi-Cal residents. In accordance with the Medi-Cal LTC Reimbursement Act (W&I Code Section 14126.023) the FRVS process, as specified below, is the result of collaboration and agreement between the Department (in conference with a professional consulting company) and long-term care stakeholders, which has resulted in a process that replaces the historical accounting cost method for the reimbursement of capital costs.

Proposed subsection (a) specifies how the Department calculates the FRVS consistent with W&I Code Section 14126.023(f). For clarity purposes, the factors used to calculate a facility's base value were identified and further described in subsections (a)(1) through (6). These factors used within the calculation are consistent with the State Plan Supplement 4 to Attachment 4.19-D, pg.'s 9-14, effective August 1, 2005.

Proposed subsection (a)(1) identifies how the Department determines a facility's estimated building value and is consistent with this same process as specified under State Plan Supplement 4 to Attachment 4.19-D, pg. 10, effective August 1, 2005. The estimated building value is established by a calculation multiplying the following factors: a standard facility size of 400 square feet, the number of licensed beds in the facility, and the R.S. Means Building Construction Cost Data adjusted by a facility's location within California. Use of the R.S. Means Building Construction Cost Index to establish the measurement of building cost inflation was a determination made by the Department, a professional consulting company and long-term care stakeholders. The R.S. Means Building Construction Cost Index is updated on an annual basis. The estimated building value amount calculated will be trended forward annually to the mid-point of the rate year using the percentage change in the R.S. Means Building Construction Cost Index.

Proposed subsection (a)(2) identifies how the Department calculates a facility's estimated equipment value and is consistent with this same process as specified in the State Plan Supplement 4 to Attachment 4.19-D, pg. 10, effective August 1, 2005. The estimated equipment value is determined by multiplying the number of licensed beds by four thousand dollars; this computation is consistent with current industry standards. The estimated equipment value is then added to the estimated building value, as determined in subsection (a)(1).

Proposed subsection (a)(3) identifies how the Department determines the depreciation value of a facility, which is dependent upon a facility's age. Consistent with the State Plan Supplement 4 to Attachment 4.19-D, pg. 9, effective August 1, 2005, the age is determined by calculating the difference between the mid-point of the current rate year, and one of the following values: a facility's original license date, the year of construction, or initial loan documentation or similar documentation. These documents are considered official legal records that identify when and where initial facility operations took place. Once the age is determined, either subsection (a)(3)(A) or (a)(3)(B) will be used to determine a facility's depreciation value.

Proposed subsection (a)(3)(A) establishes that a facility is fully depreciated when the facility is 34 years or older. For facilities that are fully depreciated, the depreciation value is determined by multiplying the 1.8 percent annual depreciation rate by 34 years (the age for all facilities that are fully depreciated). This value is then multiplied by the combined estimated building and equipment value, as determined in subsections (a)(1) and (a)(2). The depreciation value calculation is the result of collaboration and agreement between the Department (in conference with a professional consulting company) and long-term care stakeholders and is consistent with this process as specified in the State Plan Supplement 4 to Attachment 4.19-D, pg. 10, effective August 1, 2005.

Proposed subsection (a)(3)(B) establishes that a facility is not fully depreciated when the facility's age is less than 34 years. For facilities that are not fully depreciated, the depreciation value is determined by multiplying the 1.8 percent annual depreciation rate by the age of the facility. This value is then multiplied by the combined estimated building and equipment value, as determined in subsections (a)(1) and (a)(2). The depreciation value calculation is the result of collaboration and agreement between the Department (in conference with a professional consulting company) and long-term care stakeholders and is consistent with this process as specified in the State Plan Supplement 4 to Attachment 4.19-D, pg. 10, effective August 1, 2005.

Proposed subsection (a)(4) identifies how to determine a facility's current facility value, which is consistent with this process as specified in the State Plan Supplement 4 to Attachment 4.19-D, pg. 11, effective August 1, 2005. In order to compute the current facility value, the depreciation value (as determined in subsection (a)(3)) shall be subtracted from the combined total of the estimated building and equipment value (as determined in subsections (a)(1) and (a)(2)). The current facility value calculation is the result of collaboration and agreement between the Department (in conference with a professional consulting company) and long-term care stakeholders.

Proposed subsection (a)(5) identifies how to determine a facility's estimated land value, which is consistent with this process as specified in the State Plan Supplement 4 to Attachment 4.19-D, pg. 11, effective August 1, 2005. The estimated land value is assessed by calculating ten percent of the estimated building value as determined in subsection (a)(1). The estimated land value calculation is the result of collaboration and agreement between the Department (in conference with a professional consulting company) and long-term care stakeholders.

Proposed subsection (a)(6) specifies how to calculate a facility's fair rental value. The fair rental value is determined by combining the current facility value, as described in subsection (a)(4), and the estimated land value, as described in subsection (a)(5); the combined total is then multiplied by a rental factor as described under Section 52000(w). The fair rental value calculation is the result of collaboration and agreement between the Department (in conference with a professional consulting company) and long-term care stakeholders and is consistent with this process as specified in the State Plan Supplement 4 to Attachment 4.19-D, pg. 11, effective August 1, 2005.

Proposed subsection (b) specifies the calculation for the capital rate component. The capital rate component is determined by dividing the fair rental value, as determined by subsection (a)(6), by the greater value of either the actual resident days for the cost reporting period, or the adjusted resident days. In cases where data is only available for days from partial year cost reports, the days will be annualized and adjusted for the capital rate component calculation. The capital rate component calculation is the result of collaboration and agreement between the Department (in conference with a professional consulting company) and long-term care stakeholders and is consistent with this process as specified in the State Plan Supplement 4 to Attachment 4.19-D, pg. 11, effective August 1, 2005.

Proposed subsection (c) (originally (a)(2)) specifies how the Department determines the costs incurred for capital improvements, modifications, replacement projects or renovations equal to or greater than five hundred dollars per bed on a total licensed-bed basis. As the result of collaboration and agreement between the Department and long-term care stakeholders, a FRVS process was developed that in effect replaces the historical accounting cost method for the reimbursement of physical plant costs (i.e. depreciation and mortgage interest or lease costs) with a component that is more closely associated with paying for the use or occupancy of a bed in a skilled nursing facility by a Medi-Cal resident. In accordance with H&S Code Section 128730 and Title 22, CCR Section 97040 and in order to receive reimbursement for capital costs incurred, facilities must submit to OSHPD the cost report “Capital Additions, Improvements, and Replacements” (Form 10.6) available at http://www.oshpd.ca.gov/hid/products/ltc/manual/reportform.xls, in lieu of supplemental schedules. The OSHPD Form 10.6 is intended to collect information on capitalized costs incurred for major capital improvements, modifications, or renovations equal to or greater than five hundred dollars per bed, on a total licensed bed basis. The Department will use this information to convert the costs incurred (reported and approved from the Form 10.6) into an equivalent number of new beds. These costs incurred for facility improvements are used as an adjustment factor to lower the age of a facility. It is beneficial for a facility to pursue capital expenditures because the value of “new beds” within a facility may lead to a higher reimbursement rate. When capital expenditures are converted into the equivalent number of new beds, these new beds are averaged in with the age of the existing beds to create a lower weighted average age of beds that in turn represents the facility’s age. Through the 15-Day Public Availability, published on February 17, 2011, the following amendments were proposed: 1) The phrase “If a facility adds or replaces beds, these new beds” was replaced with “The equivalent number of new beds”; and 2) The sentence “The facility’s age shall be used in the depreciation as calculated in subsection (a)(3).” was added. These amendments were based on comments received during the 45-Day Public Comment Period and consideration of further stakeholder input.

Proposed subsection (d) (originally (b)) is based on W&I Code Section 14126.023(f)(2) that mandates for the 2006-07 rate year and subsequent rate years that the capital costs calculation, as described in subsection (a), reported for all facilities (in the aggregate) shall not exceed eight percent of the FRVS aggregate payment received from the Department in the prior rate year. The intent of this subsection is applicable to the 2006-07 rate year and beyond, because the facility-specific rate-setting system was initiated in the 2005-06 rate year, which did not use the current facility-specific methodology for the 2004-05 rate year, so there is no “annual increase” to base this upon for the 2005-06 rate year. Through the 15-Day Public Availability, published on February 17, 2011, this subsection was amended to replace “aggregate payment,” with “cost component.” This amendment was based on comments received during the 45-Day Public Comment Period and consideration of further stakeholder input, and is consistent with W&I Code Section 14126.023(f)(2).

Adopt Section 52506. Direct Pass-Through Costs Category.

The proposed adoption of Title 22, CCR Section 52506 is necessary to describe how the Direct Pass-Through Costs Category portion of the rate will be calculated and what data will be used.

Proposed subsection (a)(1) describes what comprises direct pass-through costs, which are consistent with those specified under the State Plan Supplement 4 to Attachment 4.19-D, pg. 14, effective August 1, 2005. These costs (excluding those related to the QAF) are consistent with those specified under W&I Code Section 14126.023(a)(5). The Medi-Cal portion of the facility quality assurance fee, which is established under H&S Code Section 1324.21, is included as a direct pass-through cost because facilities do not have control over this amount paid to the Department. The long-term care stakeholders proposed this as a direct pass-through to insure that facilities are refunded the portion of program funds that are generated by the payment of this fee. Through the re-adoption of the emergency regulations, effective January 18, 2011, “liability insurance costs” was removed to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(a)(5)(B).

Proposed subsection (a)(2) establishes how the Medi-Cal proportional share of the facility’s pass-through costs are calculated, which is consistent with the State Plan Supplement 4 to Attachment 4.19-D, pg. 14, effective August 1, 2005, and with W&I Code Section 14126.023(a)(5). Although the facility-specific rate methodology calculates the rate using a facility’s total cost and total resident days, as described under Section 52500(b) of this statement of reasons, the Department will only pay for the Medi-Cal portion of these expenses, as direct pass-through costs, which is consistent with W&I Code Section 14126.023(a)(5). This calculation is achieved by determining the proportionate number of Medi-Cal days to total resident days, and then applying this proportion to the direct pass-through costs.

Proposed subsection (b) describes the basic calculation for the property tax pass-through per diem, which is part of the rate calculation. In accordance with State Plan Supplement 4 to Attachment 4.19-D, pg. 6, effective August 1, 2005, it is a standard practice to establish the prospective per diem payment for each applicable facility on a per resident day basis, based upon the cost categories (including direct pass- through costs). It is necessary to determine daily/per diem costs in order to be parallel with calculations used in other cost categories, by dividing allowable property tax costs by total resident days.

Proposed subsection (b)(1) specifies how the Department will update the property tax pass-through costs for facilities subject to reimbursement. In accordance with State Plan Supplement 4 to Attachment 4.19-D, pg. 15, effective August 1, 2005, the Department will update property tax pass-through costs at two percent annually, in order to adjust costs. This property tax update calculation is consistent with that used and proven to be effective in the past, which was known as the “two percent adjustment” and was standard practice under the previous methodology system. This “two percent” is the maximum allowable legal limit for property tax increases imposed by Proposition 13, and is therefore a significant allowable value from the departmental perspective (given to long-term care industry providers).

Proposed subsection (b)(2) specifies how the Department will adjust these property tax pass-through costs (described under subsection (b)(1)), which is in a manner consistent with the State Plan Supplement 4 to Attachment 4.19-D, pg. 15, effective August 1, 2005. This adjustment method was the result of collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders. This collaboration resulted in the decision to adjust property tax costs from the mid-point of the cost reporting period (calendar year) to the mid-point of the current rate year (fiscal year for which the facilities are currently applying for reimbursement, not based on a standard calendar year) in order to reflect the impact of cost adjustments as a result of reporting lags.

Proposed subsection (c) specifies how the Department will determine daily pass-through costs for the facility license fees accumulated for the designated number of licensed beds, as referenced within the State Plan Supplement 4 to Attachment 4.19-D, pg. 15, effective August 1, 2005. The formula used to calculate these pass-through costs for license fees will multiply the current annual fee (per licensed skilled nursing bed, as determined by the Department of Public Health’s Licensing and Certification Division) by the total number of licensed facility beds (that exist within the given facility). The value derived from this calculation will then be divided by the total number of resident days accrued within the facility for the given rate year, in order to calculate a daily per diem amount. This direct pass-through costs formula is the result of collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders.

Proposed subsection (d) describes the basic calculation for direct pass-through costs for caregiver training per diem, which is part of the rate calculation. In accordance with State Plan Supplement 4 to Attachment 4.19-D, pg. 6, effective August 1, 2005, it is a standard practice to establish the prospective per diem payment for each applicable facility on a per resident day basis, based upon the cost categories (including direct pass-through costs). It is necessary to determine daily/per diem costs in order to be parallel with calculations used in other cost categories, by dividing allowable care giver training costs by total resident days.

Proposed subsection (d)(1) describes how a facility’s care giver training costs will be adjusted, using the California CPI, as described above in this statement of reasons.

This adjustment method is consistent with the State Plan Supplement 4 to Attachment 4.19-D, pg. 15, effective August 1, 2005, and was the result of collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders. In this case the Department does not have to establish a new inflation index as is necessary for some of the other cost categories.

Proposed subsection (d)(2) specifies how the Department will adjust care giver training costs (described under subsection (d)(1)), which is in a manner consistent with the State Plan Supplement 4 to Attachment 4.19-D, pg. 15, effective August 1, 2005. This adjustment method was the result of collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders. This collaboration resulted in the decision to adjust care giver training costs from the mid-point of the cost reporting period (calendar year) to the mid-point of the current rate year (fiscal year for which the facilities are currently applying for reimbursement, not based on a standard calendar year) in order to reflect the impact of inflation due to reporting lags.

Proposed subsection (e), which pertained to professional liability insurance costs, was removed through the re-adoption of the emergency regulations, on January 18, 2011. This subsection was removed to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(a)(5)(B) that established these costs as their own cost category.

Adopt Section 52507. Professional Liability Insurance Costs.

The re-adoption of the emergency regulations on January 18, 2011, included a new Section 52507, which was necessary to describe how the Professional Liability Insurance Costs Category portion of the rate is calculated and what data is used. The adoption of this section is consistent with SB 853 (Chapter 717, Statutes of 2010), which eliminated Professional Liability Insurance Costs as a direct pass-through and established these costs under their own cost category.

Proposed subsection (a) simply describes the basic calculation for the professional liability insurance costs per diem, which is part of the rate calculation. Professional liability insurance costs are specified as a cost category under W&I Code Section 14126.023(a)(5)(B). Consistent with W&I Code Section 14126.023(b)(2), the costs under this category are divided by the total resident days, yielding the cost per diem. Through the 15-Day Public Availability, published on February 17, 2011, “professional” was included. This term was inadvertently omitted through the re-adoption process.

Proposed subsection (b) establishes the benchmark for professional liability insurance costs, including insurance deductible costs at the 75^{th} percentile of each peer group. The calculation of professional liability insurance costs as specified under this section, is consistent with W&I Code Section 14126.023(a)(5)(B). This will be the benchmark on each facility’s cost.

Proposed subsection (c) requires facilities to report supplemental data as specified under Section 52500(b), or the insurance deductible costs will be reimbursed within the administrative cost category. This language is consistent with the requirements set forth in W&I Code Section 14126.023(a)(5)(B).

Proposed subsection (d), which was amended through the 15-Day Public Availability, published on February 17, 2011, is necessary to offer provisions consistent with Sections 52503(b) and 53504(b). This subsection specifies reimbursement is the lower of either the actual inflated cost or the benchmark for the facility's peer group. The benchmarks within W&I Code Section 14026.023(a) are designed for cost control; however, if a facility's actual costs fall below that benchmark, the facility will be reimbursed for actual inflated costs because a facility cannot be reimbursed for costs not incurred. Subsection (d) as proposed through the re-adoption of the emergency regulations was moved under subsection (e), as described below.

Proposed subsection (e), is a combination of the provisions from subsections (d) and (e), as originally proposed through the re-adoption of the emergency regulations on January 18, 2011. Subsection (e) as proposed through the 15-Day Public Availability, published on February 17, 2011 describes how a facility's professional liability insurance costs will be adjusted, using the California CPI, which is described above. The California CPI is used as the inflation index for these professional liability insurance costs because it is an applicable index developed on an annual basis, while taking into consideration all inflation adjustments and values for allowable professional liability insurance costs. In this case the Department does not have to establish a new inflation index as is necessary for some of the other cost categories. This subsection also describes how each facility's liability insurance costs will be increased from the mid-point of the cost reporting period to the mid-point of the rate year. Through collaboration and agreement between the Department (in conference with the professional consulting company) and long-term care stakeholders, costs are adjusted from the mid-point of the cost reporting period (calendar year) to the mid-point of the current rate year (fiscal year for which the facilities are currently applying for reimbursement, not based on a standard calendar year) in order to reflect the impact of inflation (given that the cost reporting period took place a significant amount of time in the past, in relation to the reimbursement that facilities will receive for the current rate year).

Subsection (f) as originally proposed through the re-adoption of the emergency regulations on January 18, 2011, was removed through the 15-Day Public Availability, published on February 17, 2011. This action was based upon stakeholder input and recommendation and in accordance with the authority of W&I Code Section 14126.027(c), which allows the implementation of the Medi-Cal LTC Reimbursement Act, in whole or in part, by provider bulletin.

Adopt Section 52508. Peer Groups.

The proposed adoption of Title 22, CCR Section 52508 is necessary to identify the peer groups within which the FS/NF-Bs in each county shall be placed for purposes of calculating the facility-specific reimbursement. “Peer group” is defined in Section 52000 (u) and the reason for this definition can be found above in the definitions portion of this statement of reasons.

Proposed subsection (a) lists the peer groups and the counties that fall under each peer group. Pursuant to W&I Code Section 14126.023(b)(2), geographic peer grouping shall be a component of the facility-specific reimbursement methodology. The percentile caps for FS/NF-Bs labor, direct and indirect care non-labor, administrative and professional liability insurance costs are computed on a peer group basis determined by the following factors: geographic urban/rural status, median/average direct care per diem costs, and the frequency of provider facilities within each county. The median per diem direct resident care cost for each county is subject to a statistical clustering algorithm, used to determine the peer groups identified within this subsection.

Proposed subsection (b) specifies that FSSA/NF-Bs shall be their own peer group, as opposed to the peer groups identified for FS/NF-Bs under subsection (a). The number of FSSA/NF-Bs in California are limited. However, the direct care per diem costs for these few facilities are significantly higher than those of FS/NF-Bs. Due to this variation in size and operational costs it is logical to cluster these facilities into their own peer group to avoid the possibility of skewing costs for other (non-subacute) facilities affected by the facility-specific rate-setting methodology.

Proposed subsection (c) specifies that the counties in California that do not have Medi-Cal skilled nursing days are excluded from the peer groups mentioned in subsection (a). Medi-Cal skilled nursing days are required for a facility participating in the Medi-Cal program. If a facility does not have Medi-Cal skilled nursing days then that facility is either non-certified (not a participant in the Medi-Cal program) or de-certified (not allowed to participate in the Medi-Cal program). The counties that have no Medi-Cal skilled nursing days are outside of the Medi-Cal program and thus not included in a peer group or considered in the facility-specific rate-setting methodology.

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

The proposed adoption of Title 22, CCR Section 52509 is necessary to specify the rate-setting methodology for state owned FS/NF-Bs.

This section outlines the method used to determine FS/NF-B rates for these types of facilities, which is consistent with the State Plan Supplement 4 to Attachment 4.19-D, Pg 17, effective August 1, 2005, that specifies prospective payments to state-owned and operated FS/NF-Bs will be based on the peer-group weighted average Medi-Cal reimbursement rate.

Adopt Section 52510. Rate-Setting For Newly Certified Facilities.

The proposed adoption of Title 22, CCR Section 52510 is necessary to specify the rate-setting methodology for facilities that are newly certified to participate in the Medi-Cal program; when the change to a facility-specific rate methodology will occur; and how the rates are calculated.

Proposed subsection (a) specifies that newly certified facilities (FS/NF-Bs and FSSA/NF-Bs) will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. Within this statement of reasons Section 52000(u) describes the definition of a peer group and Section 52508 specifies the geographic peer groups. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(1). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Newly certified facilities will receive this peer-group weighted average Medi-Cal reimbursement rate until the required audited cost report data becomes available as specified in subsections (b)(1) and (b)(2). Proposed subsection (a) cross references subsection (b)(1) and (b)(2) for clarity to specify for facilities when the peer-group weighted average Medi-Cal reimbursement rate ends and their facility-specific rate begins.

Proposed subsection (b)(1) specifies that when a newly certified FS/NF-B has six months of Medi-Cal cost report data that has been audited, the Department shall calculate a facility-specific reimbursement rate. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(1)(A). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Proposed subsection (b)(2) specifies that when a newly certified FSSA/NF has twelve months of Medi-Cal audited cost report data available, the Department shall calculate a facility-specific reimbursement rate. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(1)(B). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Adopt Section 52511. Rate-Setting For De-Certified Facilities.

The proposed adoption of Title 22, CCR Section 52511 is necessary to specify the rate-setting methodology for facilities that are no longer certified to participate in the Medi-Cal program; when the change to a facility-specific rate methodology will occur; and how the rates are calculated.

Proposed subsection (a) specifies that facilities (FS/NF-Bs and FSSA/NF-Bs) de-certified for less than six months will continue to receive the facility per diem reimbursement rate in effect prior to de-certification. Within this statement of reasons Section 52000(f) describes the definition of “de-certified”. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(2). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Proposed subsection (a)(1) specifies that when a decertified FS/NF-B has six months of Medi-Cal audited cost report data available, the Department shall calculate a new facility-specific reimbursement rate. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(2)(A). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Proposed subsection (a)(2) specifies that when a decertified FSSA/NF B has twelve months of Medi-Cal audited cost report data available, the Department shall calculate a facility-specific reimbursement rate. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(2)(B). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Proposed subsection (b) specifies that facilities (FS/NF-Bs and FSSA/NF-Bs) de-certified for six months or longer will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. Within this statement of reasons Section 52000(u) describes the definition of a peer group and Section 52508 specifies the peer groups. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(3). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Proposed subsection (b)(1) specifies that when a decertified FS/NF-B has six months of Medi-Cal audited cost report data available, the Department shall calculate a facility-specific reimbursement rate. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(3)(A). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Proposed subsection (b)(2) specifies that when a decertified FSSA/NF B has twelve months of Medi-Cal audited cost report data available, the Department shall calculate a facility-specific reimbursement rate. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(3)(B). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Adopt Section 52512. Rate-Setting For Facilities with Changes of Ownership.

The proposed adoption of Title 22, CCR Section 52512 is necessary to specify the rate-setting methodology for facilities with changes in ownership; when the change to a facility-specific rate methodology will occur; and how the rates are calculated.

Proposed subsection (a) specifies that facilities (FS/NF-Bs and FSSA/NF-Bs) with changes in ownership will continue to receive the facility per diem reimbursement rate in effect with the previous owner. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(4). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Proposed subsection (b)(1) specifies that when a FS/NF-B has six months of Medi-Cal audited cost report data available, the Department shall calculate a facility-specific reimbursement rate. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(4)(A). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Proposed subsection (b)(2) specifies that when a FSSA/NF B has twelve months of Medi-Cal audited cost report data available, the Department shall calculate a facility-specific reimbursement rate. After the original filing of this regulatory action on July 22, 2010, and before the re-adoption of the emergency regulations on January 18, 2011; SB 853 (Chapter 717, Statutes of 2010) added W&I Code Section 14126.023(c)(4)(B). The statute reflects the language under this subsection as originally proposed, thus the regulation text is consistent with current statute.

Adopt Section 52513. Change in Facility Fiscal Period.

The proposed adoption of Title 22, CCR Section 52513 is necessary to specify what cost report data is used for rate-setting when a facility changes its' fiscal period.

This section describes which cost report data will be used for rate-setting when a facility changes their fiscal period for cost reporting. W&I Code Section 14126.023(i)(1) states that the Department will use the most recent cost reporting data period available. If a facility changes their facility period, there may be more then one cost report filed in a calendar year used for rate-setting. This section clarifies that the last cost report filed within a calendar year will be used for rate-setting.

Adopt Section 52514. Out-of-State Providers.

The proposed adoption of Title 22, CCR Section 52514 is necessary to specify the rate-setting methodology used to reimburse out-of-state providers.

This section specifies that facilities beyond the California border that provide care to Medi-Cal recipients will receive the statewide facility-specific weighted average rate. This rate was determined by the Department to be the most reasonable alternative, as a means to pay out-of-state providers, whose facilities reside outside of the jurisdiction of the Medi-Cal LTC Reimbursement Act, and for which audited cost data would not be available. This rate is applicable only to the rate year during which the services are provided because the statewide facility-specific weighted average rate adjusts in response to different rate years.

Adopt Section 52515. Hospice.

The proposed adoption of Title 22, CCR Section 52515 is necessary to specify the rate-setting methodology used to reimburse Hospice providers.

This section specifies that Hospice providers will receive a facility-specific reimbursement rate, subject to a 95 percent ceiling of all allowable costs, for services provided to Medi-Cal residents. This reimbursement methodology/percentage ceiling of allowable costs for Hospice providers is consistent with Section 51544(a) that specifies that hospices will receive reimbursement for the lesser value of the following: the amount billed, or the amounts established under Title 42, U.S.C. Section 1396a(a)(13)(B) that specifies payment is 95 percent of the facility's Medi-Cal per diem rate, and is consistent with Section 51544(h). This hospice reimbursement provision is included under this section to clearly establish all provisions related to the facility-specific reimbursement rates in one convenient location within newly proposed Article 9.

Adopt Section 52516. Audits and Audit Adjustments.

The proposed adoption of Title 22, CCR Section 52516 is necessary to specify the timeframes and procedures for audits and audit adjustments.

Proposed subsection (a) initially established when the Department will conduct financial audits and the scope of these audits, which is consistent with State Plan Supplement 4 to Attachment 4.19-D, pg. 4, effective August 1, 2005. The establishment of the minimum financial audit schedule for FS/NF-Bs under the Medi-Cal program is also consistent with W&I Code Sections 14126.023(j)(1) and (2). Through the 15-Day Public Availability, published on February 17, 2011, the following amendments were proposed: 1) "financial" was replaced with "full-scope field;" 2) "all" and "facilities and home offices" were added; and 3) "These audits may be full-scope field audits or limited scope reviews” and “or review” were removed. These amendments were based on comments received during the 45-Day Public Comment Period and consideration of further stakeholder input; and make the language consistent with W&I Code Section 14126.023(j).

Subsection (b) establishes that audited cost report data will be used within the facility-specific reimbursement rate development process, which is consistent with the State Plan Supplement 4 to Attachment 4.19-D, pg. 4, effective August 1, 2005, and W&I Code Sections 14126.023(j)(1), (2) and (3) and (k)(1). It is imperative to establish this standard within this subsection to demonstrate how the Department will compare all audited costs reported, used to calculate the facility’s reimbursement rate, with the facility’s audited expenditures from the given rate year, in order to determine whether or not any discrepancies exist. If the Department reviews the audited cost report data and determines that there is a difference between the costs reported and the audited facility expenditures, the Department will adjust the reimbursement rate prospectively. Through the re-adoption of the emergency regulations on January 18, 2011, “or reviewed” was removed from this subsection to be consistent with SB 853 (Chapter 717, Statutes of 2010), specifically W&I Code Section 14126.023(i).

Subsection (c) specifies the Department’s process in relation to finding an overpayment made to a facility. If an overpayment is found, through discrepancies identified between reported and audited data, self-reported overpayments from facilities, or any additional situations in which overpayments may occur, the Department shall follow the recovery process outlined in W&I Code Section 14126.023(j)(4) and Title 22 CCR Section 51047. Section 51047 describes the “Recovery of Overpayments” process in relation to mandatory time frames, the methods used to collect overpayments including: lump sum payments by the provider, a repayment agreement executed between the provider and the Department, offsets against current payments due to the provider, and any other method of recovery available to and deemed appropriate by the Director, in addition to other provisions that may be applicable to the given process. The cross references to the statute and CCR sections are provided in this subsection to provide all applicable information pertaining to overpayments in one convenient location.

Proposed subsection (d) specifies that a facility has the right to appeal audit or examination findings, which is consistent with State Plan Supplement 4 to Attachment 4.19-D, pg. 5, effective August 1, 2005, and with related statutes and regulation sections that are simply cross referenced under subsection (d) to conveniently locate the provisions related to appeal procedures. Through the 15-Day Public Availability published on February 17, 2011, “that result in an adjustment to Medi-Cal reimbursement rates” was removed based on a comment received during the 45-Day Public Comment Period and further stakeholder input. This amendment clarifies that facilities can appeal all audit findings.

Proposed subsection (e) specifies the situation when the Department shall make a retroactive adjustment in the facility-specific rate, which is consistent with State Plan

Supplement 4 to Attachment 4.19-D, pg. 5, effective August 1, 2005, and with W&I Code Section 14126.023(l).

Adopt Section 52600. Provider Bulletin Authority.

The proposed adoption of Title 22, CCR Section 52600 is necessary to specify the time period under which provisions from the Provider Bulletins shall remain valid.

H&S Code Section 1324.23(c) and W&I Code Section 14126.027(c), provides an end date for the Department's authority to regulate by means of a Provider Bulletin for the QAF and the Medi-Cal LTC reimbursement methodology. At present, that end date is July 31, 2012. Section 52600 makes clear that the standards and regulatory provisions set forth in the Provider Bulletins under the authority of W&I Code Sections 14126 through and including 14126.035, and H&S Code Sections 1324.20 through and including 1324.30, shall remain valid when applied to rate years prior to the initial effective date of these emergency regulations.

<u>STATEMENTS OF DETERMINATION</u>

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 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 made a determination that the 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 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.

D. EFFECT ON SMALL BUSINESSES

The Department has determined that the regulations would not affect small business because 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 regulations would have no impact on housing costs.

Final Statement of Reasons (FSOR) Addendums

Addendum I (Summary of 45-Day Comments and Responses) provides the following information: the Comment Letter, the Subject/Comment Number, the Comment, and the Response to the Comment.

Addendum II (Summary of 15-Day Public Availability Comments and Responses) provides the following information: the Comment Letter, the Subject/Comment Number, the Comment, and the Response to the Comment.