INITIAL STATEMENT OF REASONS

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

This emergency regulatory action amends the California Code of Regulations (CCR), Title 22 to reflect reimbursement rates established by the Department for specific types of facilities providing long-term care services to Medi-Cal beneficiaries. The rate years are August 1, through July 31 of 2004-05, 2005-06 and 2006-07. In the Budget Acts of 2004-05, Items 4260-101-0001 and 4260-101-0890 (Ch. 208, Stats. 2004); 2005-06, Items 4260-101-0001 and 4260-101-0890 (Ch. 38, Stats. 2005); and 2006-07, Items 4260-101-0001 and 4260-101-0890 (Ch. 48, Stats. 2006), the Legislature appropriated funding to pay these rates. The reimbursement rates established through this regulatory action include the Quality Assurance Fee (QAF), pursuant to Health and Safety (H&S) Code Section 1324.21.

This regulatory proposal supports the intent of the initiating legislation as specified under W&I Code Section 14000, which states the purpose of Chapter 7, Basic Health Care is to afford qualifying individuals (such as the aged or disabled) employment of health care services in a manner equitable to the general public and without duplication of benefits available under other federal or state laws.

Within Chapter 7, Section 14105 specifies that the Director shall prescribe policies and regulations for the administration of the chapter, which includes the establishment of rates for payment of health care services.

The amendments proposed through this regulatory action will address the matter of establishing reimbursements rates for specific types of facilities providing long-term care services to Medi-Cal beneficiaries. These amendments will directly benefit these Medi-Cal providers through the update of their specific rates of reimbursement, which facilitates the delivery of these vital long-term care services to beneficiaries. In addition to meeting the goals of the authorizing statutes as described above, these emergency regulations ensure the proper and efficient administration of the Medi-Cal program in accordance with the federal and state laws that govern the Program's rules of participation and funding.

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

Section	Service	Description
51510(e)(1)	Nursing Facility Level A Services	Subsection (e)(1) is amended to add a chart which updates rates for the effective rate years.
51510.1(d)	Intermediate Care Services for the Developmentally Disabled	Subsection (d) is amended to update effective rate years and corresponding rates.

Section	Service	Description
51510.1(e) & 51510.1(f)	Intermediate Care Services for the Developmentally Disabled	A new subsection (e) is added because this language was inadvertently omitted through a previous regulatory action (DHCS-03-03E, Long-Term Care Reimbursement [OAL file #2010112903C]). The Department is involved in determining cost-based reimbursement for state operated facilities, so this provision must be included. Prior subsection (e) is re-designated as subsection (f).
51510.2(a)	Intermediate Care Services for the Developmentally Disabled – Habilitative	Subsection (a) is amended to update effective rate years and corresponding rates.
51510.3(a)	Intermediate Care Services for the Developmentally Disabled – Nursing	Subsection (a) is amended to update effective rate years and corresponding rates.
51511(a) 51511(a)(1) 51511(a)(2) 51511(a)(2)(A) – (C) 51511(a)(2)(E) - (G) 51511(a)(4)	Nursing Facility Level B Services	Subsection (a) includes a reference to H&S Code Section 1324.21 for the QAF program, implemented 8/1/04. The amended rates effective 8/1/04, for the 2004-05 rate year, reflect the updated facility costs plus the QAF. Subsections: (a)(1), (a)(2), (a)(2)(A)-(C), (a)(2)(E)-(F) and (a)(4) are amended to update effective rate years and corresponding rates. Charts containing audit disallowance factors and Distinct Part Nursing Facilities rates are included along with non-substantial grammatical changes. Beginning with the 2005-06 rate year, Subsection (a)(1) does not include Freestanding Nursing Facility Level B rates (excluding Distinct Part facilities). These rates are published via provider bulletin and a facility-specific rate letter is sent to each provider, in accordance with AB 1629 (Stats 2004, Ch. 875). In addition, in subsection (a)(2)(G) a typographical error is corrected in the cross reference.
51511.5(a)(1) 51511.5(a)(2)	Nursing Facility Services – Subacute Care Reimbursement	Subsections: (a)(1), (a)(2)(A), (e), (f)(1), (f)(2), (f)(4) and (f)(5) are

Section	Service	Description
(A) 51511.5(e) 51511.5(f)(1) 51511.5(f)(2) 51511.5(f)(4) 51511.5(f)(5)		amended to update effective rate years and corresponding rates. Charts containing audit disallowance factors and Subacute Care Reimbursement rates are included along with non-substantial grammatical changes. Additionally, subsection (a)(1) includes a reference to H&S Code Section 1324.21 for the QAF program, implemented 8/1/04. The amended rates effective 8/1/04, for the 2004-05 rate year, reflect the updated facility costs plus the QAF. Beginning with the 2005-06 rate year, Subsection (a)(1) does not include Freestanding Adult Subacute Facility rates. These rates are published via provider bulletin and a facility-specific rate letter is sent to each provider, in accordance with AB 1629 (Stats 2004, Ch. 875).
51511.6(a)-(c)	Nursing Facility Services – Pediatric Subacute Care Reimbursement	Subsections (a) – (c) are amended to update effective rate years and corresponding rates. Charts containing Pediatric Subacute Care Reimbursement rates are included along with non-substantial grammatical changes.
51535(d)	Leave of Absence	Subsection (d) is amended to update effective rate years and corresponding rates. A chart containing Leave of Absence rates is included along with non-substantial grammatical changes.
51535.1(d)	Bed Hold for Acute Hospitalization	Subsection (d) is amended to update effective rate years and corresponding rates. A chart containing Bed Hold For Acute Hospitalization rates is included along with non-substantial grammatical changes.
54501(b)	Adult Day Health Care Services	Subsection (b) is amended to update effective rate years and corresponding rates. A chart containing Adult Day Health Care Services rates is included along with

Section	Service	Description
		non-substantial grammatical changes.

EXPLANATION OF CHANGES AND DATES

1. Reimbursement Rates

(a) The reimbursement rates are updated to reflect data from each facility's annual or fiscal period closing cost report (except for Pediatric Subacute Care facilities where updated rates are based on a model). Reported costs are adjusted based on audits of reported costs performed by the Department's Audits and Investigations Program, Financial Audits Branch. These rates represent the maximum amount paid for services provided on or after August 1, of the effective rate year.

(b) This regulatory package addresses three effective rate years (2004-05, 2005-06 and 2006-07). The regulation sections identified in this package are amended to include charts that reflect the effective rate years and the corresponding rates.

(c) Sections 51511(a)(2)(A-C) and (E-F) are amended to reflect the methodology as described below in the section titled ANNUAL LONG-TERM CARE REIMBURSEMENT METHODOLOGY. Actual effective rate years are replaced with a general reference to the effective rate year to accommodate the multiple rate years specified in this regulatory proposal and to accommodate future regulatory amendments.

2. Audit Disallowance Factor and Dates

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

ANNUAL LONG-TERM CARE REIMBURSEMENT METHODOLOGY

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

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

All cost reports had a fiscal reporting period ending in the two years prior to the effective rate except for DP/NF-Bs and subacute providers. Cost reports for DP/NF-Bs had a fiscal reporting period ending between January 1, and December 31, two calendar years prior to the beginning of the effective rate year. Cost reports for subacute facilities had a fiscal reporting period ending between January 1, and December 31, three calendar years prior to effective rate year.

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

COST COMPONENTS USED TO PROJECT COSTS

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

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

ADD-ONS

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

The State Plan provides that when federal or state statutes or regulations impose new requirements on facilities after the cost reporting period, which add additional provider costs that would have not been reflected in provider cost reports used to establish the

rates, projected costs must be increased by an appropriate add-on to reflect these additional costs. These cost add-ons, based on changes mandated by statute or regulation, are mandatory cost add-ons under the State Plan.

The State Plan also provides that the Department has the discretion to provide cost add-ons to projected costs to reflect "extraordinary costs" experienced by providers that would not have been reflected in the fiscal periods for the cost reports used to establish rates. When the Department was establishing the rates for the 2004-05, 2005-06 and 2006-07 rate year, no add-ons were given.

The Department also concluded that the rates established for the 2004-05, 2005-06 and 2006-07 rate years were sufficient to assure that there would be enough long-term care providers to provide adequate access to quality long-term care services for Medi-Cal beneficiaries in need of such services. Thus, providing additional cost add-ons in order to further increase rates was unnecessary.

PROVIDER INPUT

The Department accepts input from industry representatives and organizations as part of the rate setting process. The California Association of Health Facilities, the California Hospital Association (previously known as California Healthcare Association), the Developmental Services Network, and Beverly Enterprises are among the groups that participated in discussions, or provided input to the Department's Medi-Cal Benefits, Waiver Analysis and Rates Division staff during the Department's rate setting process.

SUPPORTING DOCUMENTATION

1. Study to Develop Labor Index for Long-Term Care Facilities, 2004-05 Rate Study, Report Number 01-04-01 (July 2004)

2. Study to Develop Labor Index for Long-Term Care Facilities, 2005-06 Rate Study, Report Number 01-05-01 (June 7, 2005)

3. Study to Develop Labor Index for Long-Term Care Facilities, 2006-07 Rate Study, Report Number 01-06-01 (May 15, 2006)

4. 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

REFERENCE

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

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

STATEMENTS OF DETERMINATION

A. ALTERNATIVES CONSIDERED

The Department has determined that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which this action is proposed, or would be as effective and less burdensome to affected private persons than the emergency action.

B. LOCAL MANDATE DETERMINATION

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

C. ECONOMIC IMPACT STATEMENT

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

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

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

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

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

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

Medi-Cal is a voluntary program for both service providers and beneficiaries. These emergency regulations will affect only those long-term care facilities that choose to participate in the Medi-Cal program.

The Department has determined that the emergency regulations will not affect worker safety or the state’s environment. However, the emergency regulations will benefit the health and welfare of California residents by maintaining the continuity of the Medi-Cal program through the provision of comprehensive health care services at low cost for low-income individuals such as families with children, seniors, persons with disabilities,

children in foster care and pregnant women, including the delivery of long-term care services.

This emergency regulatory action will benefit long-term care Medi-Cal service providers through the provision of the reimbursement rates established in the Budget Acts of 2004-05, Items 4260-101-0001 and 4260-101-0890 (Ch. 208, Stats. 2004); 2005-06, Items 4260-101-0001 and 4260-101-0890 (Ch. 38, Stats. 2005); and 2006-07, Items 4260-101-0001 and 4260-101-0890 (Ch. 48, Stats. 2006) for these services, which in turn facilitates the delivery of these vital services to beneficiaries.

D. EFFECT ON SMALL BUSINESSES

The Department has determined that the emergency regulations would only affect small businesses that voluntarily provide long-term care services to Medi-Cal beneficiaries. The regulations do not impose any additional reporting, recordkeeping, or other compliance requirements on small businesses.

E. HOUSING COSTS DETERMINATION

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