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Billing and Policy
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Long Term Care

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Contents

AB 1629 and Associated Discriminatory Billing

Free-Standing Nursing Facility Level B (FS/NF-B) providers should be aware of the California Department of Health Services (CDHS) policy on the enforcement of the discriminatory billing provisions of *California Code of Regulations* (CCR), Title 22, Section 51501(a) and Section 51480(a).

CCR Section 51501(a) states, in part, "...no provider shall charge for any service or article more than would have been charged for the same service or article to other purchasers of comparable services or articles under comparable circumstances." Section 51480(a) states, "no provider shall bill...for the rendering of health care services to a Medi-Cal beneficiary in any amount greater or higher than the usual fee charged by the provider to the general public for the same service." These regulations are commonly referred to as the "discriminatory billing provisions."

According to CCR Section 51458.1(a)(2), when CDHS determines it has paid a provider an amount higher than the usual and customary amount charged by the provider, the difference between the amount paid by the public and the amount paid by the Medi-Cal program is considered an overpayment.

The Medi-Cal Long Term Reimbursement Act, commonly referred to as "AB 1629" (*Welfare and Institutions Code*, Section 14126, et seq., and *Health and Safety Code*, Sections 1418.81 and 1324.20, et seq.), established a change in California's rate setting system for Free-Standing (FS/NF-B) facilities that required CDHS to develop and implement a cost-based, facility-specific, reimbursement rate methodology. Due to the complex nature of the new rate system and the uncertainty related to obtaining federal approval, the federal Center for Medicaid and Medicare (CMS) authorized CDHS to adjust FS/NF-B rates effective to August 1, 2005. In addition, CDHS paid a rate increase pursuant to *Health and Safety Code*, Section 1324.28(a)(2) for the period August 1, 2004 to July 31, 2005. In some cases, the adjusted rates may have resulted in the amount paid by Medi-Cal for Level B services to exceed the usual and customary per diem rates paid by the general public or paid by other payer categories for Level B services. Technically, this creates an overpayment situation in violation of CCR Sections 51501(a) and 51480(a).

CDHS is aware that due to the complexities surrounding AB 1629 and the implementation of the new rate methodology, providers may have been unable to avoid overbilling for dates of service from August 1, 2004 through April 30, 2006. Therefore, CDHS will not consider the amounts paid by the Medi-Cal program to FS/NF-Bs in excess of those paid by private or other purchasers of Level B services during the above time period to constitute discriminatory billing per CCR Sections 51501 (a) or 51480(a), or an overpayment per CCR Section 51458.1(a)(2).

Other discriminatory billing practices detected by CDHS prior to, or subsequent to August 1, 2004 through April 30, 2006, or unrelated to the implementation of AB 1629, will not be excused.

Amendments to AB 1629 Facility-Specific Reimbursement Methodology

The California Department of Health Services (CDHS) publishes instructions in the *Medi-Cal Update* related to California *Welfare and Institutions Code* Section 14126 and *Health and Safety Code* Section 1324.20 et seq., added by Assembly Bill (AB) 1629. CDHS has amended the facility-specific reimbursement methodology policy published in the October 2005 *Medi-Cal Update*. Amendments are indicated with bold, underlined type in the following sections.

Note: The text and numbers in the "Example of FRVS Per Diem Calculation" at the end of §207 have not been amended.

Any questions or comments regarding these instructions should be directed in writing to:

California Department of Health Services
Rate Development Branch
Attn: Long-Term Care System Development Unit
MS 4612
1501 Capitol Avenue, Suite 71.4001
P.O. Box 99417
Sacramento, CA 95899-7417

Questions or comments may also be sent via E-mail to **ab1629@dhs.ca.gov**.

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

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

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

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

Please see **AB 1629**, *page 3*

AB 1629 *(continued)*

§204 Labor Cost Category

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

(a) Direct resident care labor costs of permanent full or part time facility employees include salaries, wages, and benefits related to routine nursing services personnel employed directly by the facility. Routine services include nursing, social services, and activities. Direct resident care labor costs include labor expenditures associated with permanent direct care employees. These services include expenditures associated with contract, registry or temporary agency staffing. These costs are limited to the 90th percentile of each respective peer-group. CDHS will calculate the direct resident care labor daily payment from the FS/NF-Bs and FSSA/NF-Bs actual allowable Medi-Cal cost reported on the most recent published cost report, as adjusted for audit findings. The ceiling for each daily payment will be the 90th percentile of each peer-group allowable Medi-Cal direct resident care labor cost. CDHS will reimburse each facility either at actual cost or the ceiling for its peer group, whichever is lower. CDHS will also establish an inflation index, based on CDHS labor study using the most recent industry-specific historical wage data as reported to OSHPD. CDHS will apply this index to allowable direct resident care labor daily costs. Each facility's direct resident care labor costs will be increased from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

   i. **For purposes of facility-specific reimbursement, other direct care personnel are defined to be skilled nursing facility employees, activities personnel, and social workers. The direct care labor cost grouping includes both permanent and temporary agency staff.**

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

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

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

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

Please see **AB 1629**, *page 4*

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

i. **For purposes of facility-specific reimbursement, labor costs, subject to the labor driven operating allocation are for employer labor expenses attributable to the direct full-time or part-time employees of the nursing facility. For example, employees of a contract cleaning services are not employees of a nursing facility for purposes of labor law; they are employees of the cleaning services.**

§207 Capital Costs Category

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

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

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

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

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

Please see **AB 1629**, *page 5*

AB 1629 *(continued)*

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

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

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

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

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

(d) If the capital cost category for all FS/NF-Bs and FSSA/NF-Bs in the aggregate for the 2006 – 2007 or 2007 – 2008 rate year exceeds eight percent of the prior rate year's cost category, CDHS will reduce the capital FRVS cost category for each and every FS/NF-B and FSSA/NF-B in equal proportion. **The maximum annual increase for the capital cost category for all facilities in the aggregate shall not exceed eight percent of the prior year's FRVS cost component on an aggregate total cost basis.**

Example of FRVS Per Diem Calculation

Example Assumptions

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

Base Value Computation

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

FRVS Per Diem Calculation

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

Please see **AB 1629,** *page 6*

AB 1629 *(continued)*

Example of FRVS Per Diem Calculation With Improvement Modification

Example Assumptions

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

Modified Facility Age Calculation

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

Weighted Average Age

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

Modified Base Value Computation

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

Modified FRVS Per Diem Calculation

FRVS Per Diem	
(Rental factor x modified base value)/(total resident days)	$ 8.63

§208 Direct Pass-Through Costs.

Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, the Medi-Cal portion of the skilled nursing facility quality assurance fee, and new state and federal mandates for the applicable rate year. **All pass-through costs are subject to audit and reasonableness cost limitations.**

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

Caregiver training costs are defined as a formal program of education that is organized to train students to enter a caregiver occupational specialty. Until the Medi-Cal cost report is revised to specifically identify these costs, FS/NF-Bs and FSSA/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting. The Medicare reimbursement principles consistent with Title 42, *Code of Federal Regulations*, Part 413 will be used to determine reasonable allowable pass-through costs for professional liability insurance. FS/NF-Bs and FSSA/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

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

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

Please see **AB 1629**, *page 7*

AB 1629 *(continued)*

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

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

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

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

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

Multi-Level Retirement Community Quality Assurance Fee Exemption List and Policy for Free-Standing Skilled Nursing Facilities Level-B

Introduction
Health and Safety Code, Sections 1324.20 through 1324.30 require the California Department of Health Services (CDHS) to implement a Quality Assurance Fee (QAF) program for Free-Standing Skilled Nursing Facilities Level-B (FS/NF-B) and Free-Standing Skilled Adult Subacute Nursing Facilities Level-B (FSSA/NF-B). The purpose of the program is to provide additional reimbursement for, and to support quality improvement efforts in, licensed skilled nursing facilities. The Centers for Medicare & Medicaid Services (CMS) approved the CDHS request to implement the QAF program. State law authorizes CDHS to use the funds from the fee to support the costs of rate increase in the Medi-Cal program.

This *Medi-Cal Update* includes information about the Multi-Level Retirement Community (MLRC) facilities that are exempt from the QAF program for the rate year 2006 – 2007. It also describes the CDHS process for requesting exemption in future rate years.

Welfare and Institutions Code, Section 14126.027(c), allows CDHS to use articles published in *Medi-Cal Updates* as alternatives to regulations until July 31, 2007, in order to implement the provisions of the statute.

Please see **QAF Exemption List,** *page 8*

QAF Exemption List *(continued)*

This *Medi-Cal Update* uses the same definition of an MLRC as described in the September 2005 *Medi-Cal Update* in section 100:

> "§ 100(f) "Multi-Level Retirement Community" (MLRC) means a provider of a continuum of services, including independent living services, assisted living services and skilled nursing care on a single campus which has not received a certificate of authority or a letter of exemption from the Department of Social Services, *Health and Safety Code* Section 1771.3."

CDHS is updating sections 140 and 141 to the instructions implementing *Health and Safety Code,* Section 1324.20(b) to clarify the facilities that are exempt for the rate year 2006 – 2007, and future rate years, and also informs the facilities of the CDHS policy requirements for any additional facilities requesting MLRC exemption from the QAF. These two sections follow September 2005 *Medi-Cal Update* Section 131, and include the final update to the exempt facilities list and a description of the process for facilities to request exemption in future rate years.

§ 140 MLRC FS/NF-Bs Exemption List – Final Update for 2006-2007 Rate Year

(a) The MLRC FS/NF-Bs listed below are exempt from the QAF program effective August 1, 2006 through July 31, 2007

(b) This list will remain in effect for the rate year August 1, 2006 to July 31, 2007, unless facility reports a change in corporate structure or business practice by May 1, 2006. Changes reported will affect the exemption prospectively for the rate year 2007 – 2008.

(c) The following MLRC FS/NF-Bs are exempt from the QAF program:

Skilled Nursing Facilities	Office of Statewide Health Planning and Development (OSHPD) Number
Alamitos West Convalescent Hospital	206301089
Ararat Nursing Facility	206194558
Artesia Christian Home	206190618
Auburn Ravine Terrace	206312230
Bayside Care Center	206400497
Belmont Convalescent Hospital	206410754
Bethany Home Society of San Joaquin County	206390796
Bethel Lutheran Home	206100684
Bethesda Home	206010760
Bixby Knolls Towers Health Care & Rehab	206190101
California Christian Home	206190122
California Home for the Aged	206100689
Canyon Villas	206374177
Casa De Modesto	206500821
Christian Heritage	206364097
Claremont Manor Care Center	206196220
Devonshire Care Center	206331193
Dorothy & Joseph Goldberg Healthcare	206374064
Earlwood, The	206190253
Eisenberg Village	206190424
Fillmore Convalescent	206560547

Please see **QAF Exemption List,** *page 9*

QAF Exemption List *(continued)*

Skilled Nursing Facilities	Office of Statewide Health Planning and Development (OSHPD) Number
Fountain Care Center	206301174
Fredericka Manor Care Center	206370708
Friends House	206492287
Glenwood Gardens	206154109
Grossmont Gardens	206374041
Hancock Park Convalescent Center	206190361
Health Center at Sierra Sunrise Village	206044028
Home for Jewish Parents	206074085
Hope Manor	206101843
Inland Christian Home	206360042
Jeanne Jugan Residence	206190947
Jones Convalescent	206010855
Kingsley Manor Care Center	206190444
Knolls West Convalescent Hospital	206364001
Knott Avenue Care Center	206301280
Las Villas De Carlsbad	206374186
Las Villas Del Norte	206371735
Life Care Center of Corona	206330206
Lincoln Glen Skilled Nursing	206431530
Lutheran Health Facility at Alhambra	206190493
Lytton Gardens, Inc.	206431865
Meadowood Health & Rehab Center	206394041
Meadows of Napa Valley, The	206284010
Mercy Retirement and Care Center	206013696
Mesa Verde	206301259
Mission Lodge Sanitarium	206190539
Monte Vista Grove Homes	206190544
Monte Vista Lodge	206370748
Nazareth House of Fresno	206100767
Nazareth House of Los Angeles	206190957
Nazareth House of San Rafael	206211023
New Bethany	206244031
Our Lady of Fatima Villa	206430840
Pilgrim Place Health Services Center	206190617
Pioneer House	206340980
Plymouth Square	206390987
Plymouth Tower	206331300
Rancho Vista	206371677
Redwoods, The	206210916

Please see **QAF Exemption List**, *page 10*

QAF Exemption List *(continued)*

Skilled Nursing Facilities	Office of Statewide Health Planning and Development (OSHPD) Number
Remington Club Health Center	206374021
Santa Teresita Manor	206196551
Sierra View Homes	206100799
Simi Valley Care Center	206560536
St. Anne's Home	206380958
St. Claire's Nursing Center	206342225
St. John of God Retirement & Care Center	206190755
St. Paul's Senior Homes & Services	206371598
Stollwood Convalescent Hospital	206571047
Twilight Haven	206100817
Venturan Convalescent Center, The	206560539
Villa Scalabrini Special Care Unit	206194113
Villa Siena	206431833
Vista Del Sol Care Center	206190227
Wine Country Care	206390894
Wish-I-Ah Care Center	206100833

(d) All MLRCs that are on the exemption list from the 2004-05 and the 2005-06 rate years must comply with the *Health and Safety Code*, Section 1324.20(b), and the September 2005 Medi-Cal Update Section 100, in order to remain on the exemption list. This includes providing independent living services, assisted living services and skilled nursing care on a single campus.

(e) Any new applicants for the 2006-07 and future years must comply with the *Health and Safety Code*, Section 1324.20(b), and the November 2005 Medi-Cal Update, Sections 140 and 141, and the additional updated requirements below in Sections 140 and 141.

(f) All MLRCs will remain exempt until they change ownership, at which time they must provide documentation to CDHS that their status has not changed. A change of ownership is defined in 42 Code of Federal Regulations Section 489.18.

(g) This list was final and effective on June 1, 2006.

MLRC FS/NF-Bs Requests for Exemption from the QAF Program in Future Rate Years

§ 141 CDHS Policy and Requirements

CDHS requires any FS/NF-B requesting exemption from the QAF program as an MLRC facility for the 2006 – 07 and future rate years to comply with the following:

(a) A facility may request an exemption once each rate year. This request must be submitted to CDHS by May 1 for the upcoming rate year. Any requests filed after the deadline will be accepted as a request for the subsequent rate year.

(b) Each facility must submit to CDHS by May 1 of each year the following documentation:

1. A copy of a current Residential Care for the Elderly (RCFE) license and Skilled Nursing Facility (SNF) license.

2. Information that proves that both the SNF and RCFE are owned by the same entity (common ownership). The facility owner's name, federal tax identification number and Medi-Cal provider number must be correct and consistent with each other.

Please see **QAF Exemption List**, *page 11*

QAF Exemption List *(continued)*

3. Any FS/NF-B that has changes to its facility's corporate structure or general business practices must provide CDHS with six or more months of cost reports as operating under the new ownership or business practice.
4. A description of the campus that indicates that the campus provides a continuum of services, including independent living services, assisted living services and skilled nursing care on a single campus.
5. If the addresses of the SNF building and the RCFE building are different, the provider must send in proof that they are on the same campus and the ownership is the same.
6. Each facility must provide its Medi-Cal provider number, federal tax identification number and the Office of Statewide Health Planning and Development number of the current owner.
7. A statement under penalty of perjury that the facility has not received a certificate of authority or a letter of exemption from the Department of Social Services, as specified in *Health and Safety Code* Section 1771.3.
8. Each facility must provide the total number of unlicensed Independent Living (IL) units and the total number of Assisted Living (AL) units.
9. If the facility licenses all of its IL and AL units under the RCFE license, the facility must demonstrate the following:
   a) The IL area is separate from the AL.
   b) There is a provision in an agreement between the resident and the facility which specifies when the level of care changes and how a transfer occurs from one facility type (IL, AL or SNF) to a higher or lower level of care.
10. The total number of SNF units must be 40 percent (40%) or less and the IL and AL units must be 60 percent (60%) or more of the total capacity of the campus. For example:
    a) Total number of IL + AL units = or > 60% of Total Capacity.
    b) Total Capacity = (IL + AL units) + SNF units.

(c) From the date of the application for exemption, CDHS will have 30 days to request any additional information.

(d) CDHS will approve or deny the request within 60 days but no later than August 1 of the rate year.

(e) For any FS/NF-B that CDHS approves as an exempt MLRC, CDHS will adjust its rates effective August 1 of each rate year.

(f) The information must be sent to:

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

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This *Medi-Cal Update* does not contain Part 2 Billing and Policy provider manual pages.