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Provider Bulletin 8-01-2005
Quality Assurance Fee
Definitions, Payment Procedures, Reporting Requirements

Provider Bulletin, No. 8-01-2005, outlined the payment procedures and reporting requirements for Freestanding Skilled Nursing Facilities subject to the new Qualify Assurance Fee, effective August 1, 2004.

Introduction

Health and Safety Code Sections 1324.20 through 1324.30* authorize the Department of Health Services (hereinafter "DHS") to implement a Quality Assurance Fee (QAF) Program for Freestanding Skilled Nursing Facility Level-Bs (FS/NF-B) and Freestanding Skilled Adult Subacute Nursing Facilities (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 DHS' waiver request to implement the QAF Program. State law authorizes DHS to use the funds from the fee to enhance federal financial participation in the Medi-Cal program.

* Added by California Assembly Bill (AB) 1629 (Statutes of 2004, chapter 875).

The provider bulletin informs skilled nursing facilities about the QAF Program, including the payment procedures and reporting requirements. *Health and Safety Code* Section 1324.21 provides that any FS/NF-B and FSSA/NF-B licensed under *Health and Safety Code* Section 1250(c) shall pay a uniform quality assurance fee per resident day.

Welfare and Institutions Code Section 14126.027(c) authorizes DHS to use provider bulletins as an alternative to regulations in order to implement the provisions of the statute. DHS is issuing the provider bulletin pursuant to this authority.

Instructions to Freestanding Skilled Nursing Facilities
For Payment of Quality Assurance Fee

§ 100 Definitions

For purposes of these Instructions, the following definitions apply:

(a) "Nursing Facility" (NF) means a health facility that DHS has licensed and certified to participate as a provider of care in the federal Medicare and Medicaid programs pursuant to *Health and Safety Code* Section 1250(k).

(b) "Freestanding Skilled Nursing Facility" (FS/NF) means any institution, place, building or agency that meets the standards of participation in Medi-Cal, which DHS has licensed and certified as a skilled nursing facility, pursuant to *California Code of Regulations*, Title 22, Sections 51121 and 51215.

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

Please see **Quality Assurance**, *page 2*

Quality Assurance *(continued)*

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

(e) "Continuing Care Retirement Community" (CCRC) means a provider of a continuum of services, including independent living services, assisted living services and skilled nursing care on a single campus that has obtained a certificate of authority to enter into continuing care contracts from the Department of Social Services, pursuant to *Health and Safety Code* Sections 1771 and 1791.

(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.

(g) "Publicly Owned and Operated Nursing Facility" (PUB) means a skilled nursing facility owned or operated by the state, city or county, or city and county, the University of California, or any other public entity.

(h) "Exempt facility" means any of the following:

(1) Continuing Care Retirement Community (CCRC) or a Multi-Level Retirement Community (MLRC).

(2) Distinct Part Nursing Facility (DP/NF).

(3) Publicly Owned and Operated Nursing Facility (PUB).

(i) "Rate year" begins August 1st.

(j) "Net revenue" means gross revenue for routine and ancillary services minus Medicare revenue for the same services and minus payer discounts or contractual allowances.

Description of the QAF Program

§101 Facilities Subject to QAF

Each FS/NF-B and FSSA/NF-B shall pay a uniform quality assurance fee per resident day, except those FS/NF-B's and FSSA/NF-B's that are exempt from the quality assurance fee under *Health and Safety Code* Section 1324.20(b).

§102 Effective Date

The effective date of the QAF is August 1, 2004.

§103 Basis for QAF - Background

(a) DHS shall base the uniform quality assurance fee on the total net revenue of all skilled nursing facilities except for those that are exempt under *Health and Safety Code* Section 1324.20(b).

(b) For the rate year 2004-2005, DHS shall base the QAF on FS/NF-B's and FSSA/NF-B's on three percent of the aggregate net revenue of skilled nursing facilities subject to the fee.

(c) For the rate year 2005-2006 and subsequent rate years through and including the 2007-2008 rate year, the QAF shall not exceed six percent of the annual aggregate net revenue for the facilities subject to the fee.

(d) DHS shall assess the QAF on each skilled nursing facility for the fiscal year irrespective of any changes in ownership, any changes in ownership interest or control, or the transfer of any portion of the assets of a facility to another owner. New owners assume the provider agreement including all assets and liabilities for payment of fees of the prior owner.

Please see **Quality Assurance**, *page 3*

Quality Assurance *(continued)*

§104 Net Revenue and Exclusions

Under *Health and Safety Code* Sections 1324.20(c)(1) and (d), "Net revenue" means total gross resident revenue for routine and ancillary services provided to all residents by a skilled nursing facility minus the following:

(a) Medicare revenue for routine and ancillary services (including payments under a Medicare managed care plan)

(b) Any payer discount and applicable contractual allowances

§105 Contributions and Debts Excluded from Gross Revenue

Charitable contributions may not be added to, and bad debts may not be subtracted from, gross revenue in calculating net revenue.

§106 Calculation of Net Revenue and QAF Rates

DHS calculates net revenue based on the prior rate year data. In order to calculate the maximum allowable QAF amount, for the state fiscal year 2004-05, DHS multiplied the aggregate net revenue by three percent (3%). For fiscal year 2005-06 and subsequent rate years through and including the 2007-08 rate year, DHS will multiply the aggregate net revenue by six percent (6%).

DHS calculates two different QAF rates, one for NFs with less than 100,000 total resident days and one for NFs with 100,000 or over total resident days, based on the maximum allowable QAF amount and total resident days for each facility group.

§107 QAF Amounts for Fiscal Year 2004-05

The QAF for state fiscal year 2004-05 shall be $3.66 per resident day for NFs with less than 100,000 total resident days and $3.17 per resident day for NFs with 100,000 or over total resident days.

§108 QAF Amounts for Fiscal Year 2005-06

The QAF for state fiscal year 2005-06 shall be $7.31 per resident day for NFs with less than 100,000 total resident days and $6.33 per resident day for NFs with 100,000 or over total resident days.

§109 QAF Amounts for Fiscal Year 2006-07

The QAF for state fiscal years 2006-07 and each subsequent year shall be recalculated based on facility respective prior rate year data.

Instructions to Free Standing Nursing Facilities For Payment of Quality Assurance Fee

Payment Instructions

§110 Payment Schedule - Monthly

Each skilled nursing facility required to pay the QAF, shall pay the QAF to DHS on a monthly basis. The QAF payment is due on or before the last day of the month following the month in which the fee is imposed.

Reporting Requirements

§120 Report of Total Resident Days

Each skilled nursing facility required to pay the QAF, shall report total annual resident days. The total days it reports shall be the same total reported to the Office of Statewide Health Planning and Development (OSHPD) during fiscal year 2004-05 and each subsequent year.

§121 Quarterly and Annual Reports

(a) Each skilled nursing facility required to pay the QAF, shall file a report with DHS on or before the last day of each calendar quarter. The Report shall include:

  (1) The facility's total resident days for the preceding quarter, and,

  (2) The QAF payments made.

Please see **Quality Assurance***, page 4*

Quality Assurance *(continued)*

(b) DHS will provide a form to report the information.

(c) All skilled nursing facilities shall report any change in ownership, change of ownership interest or control or transfer of any portion of assets within thirty-five (35) days of the change to the appropriate DHS agency. The new owner shall assume any liability for unpaid QAF fees.

(d) Each skilled nursing facility required to pay the QAF, shall report annually at the end of the fiscal year to DHS the following:

(1) The facility's total resident days, and

(2) The total QAF payments during the preceding state fiscal year.

(e) DHS shall provide a form to report total resident days and total QAF payments.

§130 Failure to Pay – Deduction from Future Payments

A facility shall pay the total QAF within sixty (60) days of the date that the QAF is due.

A facility that fails to pay the QAF within sixty (60) days is subject without additional notice to a reduction of future Medi-Cal reimbursements beginning on the sixty-first (61) day after the QAF was due.

DHS shall deduct any unpaid assessment and interest owed from any prospective Medi-Cal reimbursement payments to the facility until DHS has recovered the full amount of fees due and owed.

§ 131 Additional Sanctions

Should all or any part of the QAF remain unpaid, DHS may take either or both of the following actions:

(a) Assess a penalty equal to 50 percent of the unpaid fee amount.

(b) Delay license renewal pending payment of all debts due and owed.

Inpatient Provider Cutoff Date for Proprietary and Non-HIPAA Standard Electronic Claims Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal has established a plan to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claims transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cutoff dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Valid Delay Reason Code Necessary When Billing CCS Inpatient Claims After 6-Month Time Limit

California Children's Services (CCS) providers who submit inpatient claims as an exception to the six-month billing time limit are reminded that they must include a valid delay reason code to be processed for full Medi-Cal payment. Payments to providers who submit CCS claims after the six-month billing time limit without the required delay reason code will be reduced in accordance with Medi-Cal policy.

Refer to the *Claim Submission and Timeliness Overview* section in the Part 1 manual for more information about delay codes and reimbursement reduction for late claims. The *Payment Request for Long-Term Care (25-1) Submission and Timeliness Instuctions* section of the Part 2 manual contains a list of valid delay reason codes.

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