MEDI-CAL UPDATE Part 2
Billing and Policy
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Long Term Care

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AB 1629 Facility-Specific Rate Methodology

Audit Adjustments

The State Plan requires audit adjustment factors from prior fiscal period audits to be applied to reported costs. This means for facilities not audited during the rate-setting year that the audit adjustments based on the previous audit will be applied to the reported costs being used for rate setting.

The costs used for the current rate-setting period will be adjusted by the calculated adjustment based on the previous audit regardless if a facility revised costs due to a previous audit finding. If audit adjustments are determined by the California Department of Health Services (CDHS) as being either too high or too low (top and bottom 5 percent), CDHS will cap the audit adjustment at the peer-group weighted average amount.

An example of this is a facility not audited for their 2005 fiscal period end. The facility's 2005 fiscal period end reported costs are used to establish their August 1, 2007 rates. Those 2005 reported costs will be adjusted based on audit adjustment factors calculated from the audit performed on the 2004 fiscal period end.

This same principle was applied to the August 1, 2006 rates. Audit adjustment factors will be applied to reported costs in rate years when unaudited data is used to establish reimbursement rates. If the reimbursement rates are based on audited data, no adjustment is applied.

Supplemental Schedules

Data reported on the Supplemental Schedules must agree with the "as submitted" cost report from the Office of Statewide Health Planning and Development (OSHPD). The OSHPD number and fiscal period end on the Supplemental Schedules must both match with the OSHPD "as submitted" cost report. To the extent possible, CDHS will contact the Supplemental Schedule preparer for minor corrections. If costs cannot be corrected through minor edits, the data may be eliminated as inaccurate, incomplete or unrepresentative. Supplemental Schedules cannot be used to correct OSHPD "as submitted" reports.

Personal Liability Insurance

Personal Liability Insurance (PLI) pass-through per diems will be calculated based on the amount reported on Supplemental Schedules. PLI reported amounts will be removed from the Administration costs.

The PLI amount reported on the Supplemental Schedule 1 will be used to compute the PLI per diem when the facility's OSHPD ID and fiscal period end date match with the facility's OSHPD "as submitted" report. This amount may be validated by CDHS.

Please see **AB 1629**, *page 2*

AB 1629 *(continued)*

If the submitted Supplemental Schedule 1 is for a different fiscal period end date than the "as submitted" OSHPD report and there is no audit for the rate-setting period, the prior year's audited amount inflated by the California Consumer Price Index will be used, if available.

If the submitted Supplemental Schedule 1 is for a different fiscal period end date than the "as submitted" OSHPD report, and there is no audit for a prior rate period, a "proxy" pass-through per diem will be computed. The "proxy" PLI is based on the peer grouped weighted average for facilities that submitted a valid Supplement Schedule 1 with PLI costs.

If no Supplemental Schedule 1 was submitted, the facility pass-through will be zero.

PLI pass-through costs are not capped, but are limited by the overall annual legislative growth permitted by the AB 1629 legislation.

Medical Records
Medical records costs include costs to store, retrieve, process and dispose of patient medical records. For audited facilities, per diems are based on audited costs. For unaudited facilities, per diems are based on Supplemental Schedule 1 reported amounts. Costs are limited to the 90th percentile per diem. That limit is calculated based on unaudited facilities that reported medical records costs on an accepted Supplemental Schedule 1.

License Fees
License fees are total costs incurred for licensure of the skilled nursing facility during the cost reporting period. License fees incurred are reported on Supplemental Schedule 1. Fines and penalties are not permissible costs for the license fee per diem. Fines and penalties should not be reported on the Supplemental Schedule 1.

For facilities audited within the rate-setting period, the audit separately reports the license fees incurred. For facilities not audited within the rate-setting period, the license fees incurred are removed from the Administration costs by multiplying the average fees applicable during the cost report period, times the number of licensed beds.

For the 2004 cost report period (used for the August 1, 2006 reimbursement rates), the average license fee incurred was $217.50. For the 2005 cost report period (used for the August 1, 2007 reimbursement rates), the average license fee incurred is $218.94.

The prospective license fee per diem is computed as the number of licensed beds multiplied by CDHS Licensing and Certification fee for the applicable rate year. For rates effective August 1, 2006, this fee was $202.96. For rates effective August 1, 2007, this fee will be $254.25.

Quality Assurance Fees Per Diem
For purposes of the facility-specific reimbursement rates, the estimated Quality Assurance Fee (QAF) costs for the cost report period are removed from the Administration costs. The prospective QAF per diem reimbursed amount will be the QAF per diem for the appropriate rate year.

Caregiver Training
Caregiver training costs are costs of a formal education program designed to train students to enter a caregiver occupational specialty. Costs for the program are reported on Supplemental Schedule 1. Medicare guidelines and payment principles are used to determine allowable costs for these training programs. Only direct costs attributable to the program should be reported. Wages and salaries are direct labor and are not under the caregiver pass-through.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: medi cr ltc ex 7/8 *

* Pages updated due to ongoing provider manual revisions.