AMENDED IN ASSEMBLY SEPTEMBER 4, 2009

AMENDED IN ASSEMBLY AUGUST 31, 2009

AMENDED IN SENATE JUNE 1, 2009

AMENDED IN SENATE MARCH 9, 2009

SENATE BILL No. 117

Introduced by Senator Corbett
(Principal coauthor: Assembly Member Chesbro)

February 2, 2009

An act to amend ~~Section~~ *Sections 14525.1, 14526.1, and* 14571.2 of the Welfare and Institutions Code, relating to adult day health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 117, as amended, Corbett. Adult day health care services: *eligibility criteria:* Medi-Cal reimbursement methodology and limit.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons.

The Adult Day Health Medi-Cal Law establishes adult day health care services as a Medi-Cal benefit for Medi-Cal beneficiaries who meet certain criteria*, including, beneficiaries who meet the skilled nursing facility level of care, as specified*. ~~Under~~

This bill would modify the aforementioned criteria to, instead, provide that a beneficiary shall be eligible for adult day health care services as a Medi-Cal benefit if he or she meets a specified level of care.

Under existing law, participation in an adult day health care program requires prior authorization by the State Department of Health Care Services.

Existing law requires the department, effective August 1, 2010, to establish a reimbursement methodology and a reimbursement limit for adult day health care services on a prospective cost basis for services that are provided to each participant, pursuant to his or her individual plan of care, as specified. Existing law requires that these provisions be implemented only to the extent that federal financial participation is available.

This bill would, instead, provide that the requirement that the department establish a reimbursement methodology and reimbursement limit be effective August 1, 2012, and would make other conforming changes.

This bill would also make a technical, nonsubstantive change relating to adult day health care services.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14525.1 of the Welfare and Institutions Code is amended to read:

14525.1. (a) Except as provided in subdivisions (b) and (c), any adult eligible for benefits under Chapter 7 (commencing with Section 14000) shall be eligible for adult day health care services if that person meets all of the following criteria:

(1) The person is 18 years of age or older and has one or more chronic or postacute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested adult day health care services for the person.

(2) The person has two or more functional impairments involving ambulation, bathing, dressing, self-feeding, toileting, transferring, medication management, and hygiene.

(3) (A) Except as provided under subparagraph (B), the person requires substantial human assistance in performing these activities.

(B) The persons described in subdivisions (b) and (c) shall only require assistance in performing these activities.

(4) The person requires ongoing or intermittent protective supervision, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or

minimize deterioration of the medical, cognitive, or mental health condition.

(5) The person requires adult day health care services, as defined in Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the adult day health care program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.

(6) The person meets the ~~skilled nursing facility~~ level of care set forth in Section ~~51124~~ *51120* of Title 22 of the California Code of Regulations.

(b) A resident of an intermediate care facility for the developmentally disabled-habilitative shall be eligible for adult day health care services if that resident meets the criteria set forth in paragraphs (1) to (5), inclusive, of subdivision (a) and has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

(c) Persons having chronic mental illness or moderate to severe Alzheimer's disease or other cognitive impairments shall be eligible for adult day health care services if they meet the criteria established in paragraphs (1) to (5), inclusive, of subdivision (a).

(d) This section shall only be implemented to the extent permitted by federal law.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions without taking further regulatory action.

(f) Prior to implementing this section, the department shall meet and confer with provider representatives, including, but not limited to, adult day health care, home- and community-based services, and nursing facilities for the purpose of presenting and discussing

information and evidence to assist the department as it determines the methods and procedures necessary to implement this section.

(g) Upon the determination of the director that all necessary methods and procedures described in subdivision (f) have been ascertained and are sufficient to implement the purposes of this section, the director shall execute and retain a declaration indicating that this determination has been made. Subdivisions (a) to (e), inclusive, shall be inoperative, until the date of execution of the declaration. Upon the date of execution of such a declaration, subdivisions (a) to (e), inclusive of this section shall become operative and Section 14525 shall become inoperative.

SEC. 2. Section 14526.1 of the Welfare and Institutions Code is amended to read:

14526.1. (a) Initial and subsequent treatment authorization requests may be granted for up to six calendar months.

(b) Treatment authorization requests shall be initiated by the adult day health care center, and shall include all of the following:

(1) The signature page of the history and physical form that shall serve to document the request for adult day health care services. A complete history and physical form, including a request for adult day health care services signed by the participant's personal health care provider, shall be maintained in the participant's health record. This history and physical form shall be developed by the department and published in the inpatient/outpatient provider manual. The department shall develop this form jointly with the statewide association representing adult day health care providers.

(2) The participant's individual plan of care, pursuant to Section 54211 of Title 22 of the California Code of Regulations.

(c) Every six months, the adult day health care center shall initiate a request for an updated history and physical form from the participant's personal health care provider using a standard update form that shall be maintained in the participant's health record. This update form shall be developed by the department for that use and shall be published in the inpatient/outpatient provider manual. The department shall develop this form jointly with the statewide association representing adult day health care providers.

(d) Except for participants residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization

request shall be granted only if the participant meets all of the following medical necessity criteria:

(1) The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:

(A) Monitoring.

(B) Treatment.

(C) Intervention.

(2) The participant has a condition or conditions resulting in both of the following:

(A) Limitations in the performance of two or more activities of daily living or instrumental activities of daily living, as those terms are defined in Section 14522.3, or one or more from each category.

(B) A need for assistance or supervision in performing the activities identified in subparagraph (A) as related to the condition or conditions specified in paragraph (1) of subdivision (d). That assistance or supervision shall be in addition to any other nonadult day health care support the participant is currently receiving in his or her place of residence.

(3) The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:

(A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.

(B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.

(C) The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.

(4) A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

(5) The participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive,

of Section 14550.5, on each day of attendance, that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

(e) When determining whether a provider has demonstrated that a participant meets the medical necessity criteria, the department may enter an adult day health care center and review participants' medical records and observe participants receiving care identified in the individual plan of care in addition to reviewing the information provided on or with the TAR.

(f) Reauthorization of an adult day health care treatment authorization request shall be granted when the criteria specified in subdivision (d) or ~~(f)~~ *(g)*, as appropriate, have been met and the participant's condition would likely deteriorate if the adult day health care services were denied.

(g) For individuals residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

(h) Subdivision (e) shall become operative commencing on the first day of the month following 30 days after the effective date of the act adding this subdivision.

~~SECTION 1.~~

SEC. 3. Section 14571.2 of the Welfare and Institutions Code is amended to read:

14571.2. (a) Subject to the provisions of this section, the department shall establish, effective August 1, 2012, a reimbursement methodology and a reimbursement limit for adult day health care services on a prospective cost basis for services that are provided to each participant, pursuant to his or her individual plan of care. The prospective reimbursement methodology shall be determined by the department after consultation with the California Association for Adult Day Services and other interested stakeholders.

(b) The following definitions shall apply for purposes of this section:

(1) "Daily core services" means the services described in Section 14550.5.

(2) "Separately billable services" means services designated by the department, after consultation with the California Association for Adult Day Services, and shall include, but not be limited to, the following:

(A) Physical therapy services.

(B) Occupational therapy services.

(C) Speech and language pathology services.

(D) Mental health services.

(E) Registered dietician services.

(F) Transportation services.

(c) The prospective reimbursement methodology for the daily core services provided by each adult day health care center shall be determined by the department based on the reasonable cost of providing all of the adult day health care services included within the core services and adjusted to the particular rate year. Services and costs included in the calculation of the daily core services rate shall include, but not be limited to, all of the following:

(1) Fixed or capital-related costs representing depreciation, leases and rentals, interest, leasehold improvements, and other amortization.

(2) Labor costs other than those for the separately billable services, including direct and indirect labor and contracted staff hours required by law or regulation.

(3) All other costs exclusive of fixed or capital-related costs, leases or rentals, interest, leasehold improvements, and other amortization.

(4) Add-ons, adjustments, and audit adjustments determined annually in the calculation of the core rate to allow for changes specified in subdivision (h), until those changes are reflected in the cost report.

(5) Cost components required to comply with licensing and certification laws and regulations.

(d) (1) The daily reimbursement rates for the separately billable services shall be determined based upon the reasonable cost of providing each service, how each of the individual billable services is defined, and which professional is providing the service, subject to the scope of his or her license. These reimbursement rates shall

not exceed the Medi-Cal rates for the same service on file at the time the service is rendered.

(2) In establishing the total reimbursement limit, direct patient care labor costs may be paid at a specified discrete percentile to ensure maintenance of quality of care.

(e) The department shall determine a reimbursement limit applicable to each adult day health center peer group established pursuant to subdivision (m), taking into account total overall average costs per day of attendance for providing the entire array of adult day health care services, including the daily core services and the separately billable services. The department shall determine a reimbursement limit applicable to each adult day health care center peer group established pursuant to subdivision (m) based on cost containment principles applied to other acute care and long-term care providers.

(f) By July 1, 2010, the department shall develop, after consultation with the California Association for Adult Day Services, all of the following:

(1) An adult day health care center cost report meeting the requirements of subdivision (j) and a list of individual components to be included in the core rate calculation.

(2) The methodology and documentation necessary to establish the reimbursement rate for the separately billable services.

(3) The reimbursement rates for transportation services. Payments for transportation services shall be subject to the limit on the daily reimbursement and shall be reimbursed whether the center provides transportation directly, by use of contracted transportation, or both. The department shall review methodologies for payment for transportation services. The review of payment methodologies shall include a survey of other states' adult day health care transportation systems, and transportation reports or expert consultation relevant to nonemergency medical transportation services in the community.

(g) (1) By January 1, 2011, the department shall facilitate the training of providers in collaboration with the California Association for Adult Day Services. The adult day health care centers shall be trained in the all of the following elements:

(A) The use of the modified cost report, supplemental reports, and the accounting and reporting manual.

(B) Plan of care documentation required to support the separately billable rate components.

(C) Medical necessity and eligibility requirements and documentation.

(2) By January 1, 2011, the department, after consultation with the California Association for Adult Day Services, shall establish facility peer groupings as specified in subdivision (m).

(h) By July 1, 2011, the department, after consultation with the California Association for Adult Day Services, shall establish a methodology for calculation of the reimbursement limit, rates for the daily core services, and applicable percentiles limiting specific cost categories within the core rate.

(i) (1) By March 30, 2012, a preliminary estimate of the reimbursement limit, the reimbursement rate for individual adult health care services, and separately billable services shall be established and provided to the California Association for Adult Day Services and other interested stakeholders. The department shall allow an appropriate stakeholder comment period following this action.

(2) The information supplied to all interested stakeholders in paragraph (1) shall be compared to what would have been paid under the rate methodology in effect for the 2011–12 fiscal year.

(3) Based on the rate comparisons, a methodology to provide for a multiyear phase in of the new prospective payment may be implemented.

(4) At the time of implementation, no adult day health care center's payment shall be decreased by more than 10 percent below the rate paid in the rate year immediately preceding the first year that the rate methodology prescribed in this section is implemented. In the second and third rate years, no adult day health care center reimbursement rate shall be decreased by more than 10 percent below the adult day health care center's reimbursement rate on file at the time of the application of the next year's reimbursement rate.

(j) (1) The department, with input from the California Association for Adult Day Services and all interested stakeholders, shall develop the cost reporting form and determine the costs that are to be included and excluded from the annual cost reporting methodology.

(2) Cost reporting shall be consistent with Section 1861 of the federal Social Security Act (42 U.S.C. Sec. 1395x) and Part 413 of Title 42 of the Code of Federal Regulations.

(3) Cost reporting shall include itemization of the costs of all adult day health care services such that information necessary to determine costs associated with the core bundle of services and each of the separately billable services can be collected.

(4) The cost report or supplemental report to the cost report, as determined by the frequency the data will be required for calculation of the core rate, shall collect staffing level and salary data for all direct and indirect patient care staff, arranged through either employment or contract.

(5) All adult day health care centers participating in the Medi-Cal program shall maintain books and records according to generally accepted accounting principles and the uniform accounting systems adopted by the state, and shall submit annual cost reports directly to the department.

(k) (1) The department may exclude any cost report or portion thereof that it deems to be inaccurate, incomplete, or unrepresentative, consistent with the policies established in paragraph (2) of subdivision (j). For facilities that fail to file cost reports with the department pursuant to this section, the department shall reimburse those facilities at 10 percent below the lowest reimbursement limit established in the facility's peer group pursuant to subdivision (d).

(2) Cost report data shall be validated by using comparisons to salary surveys and health industry administrative data maintained by the Office of Statewide Health Planning and Development and other state agencies. If cost report data is not statistically valid for a given peer group, survey statistics shall be used as a proxy to substitute for the cost report data.

(3) Cost report data for any adult day health care center that has closed or is no longer a Medi-Cal participating facility shall be excluded from the rate calculation.

(4) The specific process for maintaining cost data and submitting cost reports shall be developed after consultation with the California Association for Adult Day Services.

(*l*) Field audits shall be performed by the department in accordance with all of the following laws and regulations:

(1) Section 1861 of the Social Security Act (42 U.S.C. Sec. 1395x) and Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(2) Sections 413.9, 433.32, and 483.10 of, Part 413 of, Title 42 of the Code of Federal Regulations.

(3) Centers for Medicare and Medicaid Services Publication 15-1 (federal Department of Health and Human Services Manual).

(4) Chapter 5 (commencing with Section 54001) of Division 3 of, and Chapter 10 (commencing with Section 78001) of Division 5 of, Title 22 of the California Code of Regulations.

(5) Sections 14170 and 14171.

(6) Relevant portions of the California Medicaid State Plan.

(m) (1) In accordance with field audit requirements, adult day health care centers shall be placed in a minimum of three designated peer groupings. Each adult day health care center in each of the designated peer groupings shall be audited on an annual basis.

(2) If for any reason a field audit was not performed, the average audit adjustment of the peer grouping shall be applied.

(3) The peer groupings shall include, at minimum, geographic differences and size of facility. The need for additional groupings shall be periodically reevaluated to ensure that the peer groupings remain relevant on a statewide basis.

(4) The department shall analyze and evaluate the data obtained through peer grouping analysis in order to determine if additional peer groupings or data elements are necessary for refinement of the peer groupings.

(5) After analyzing the data pursuant to paragraph (4), the department may increase the number of peer groupings or change the criteria to reflect pertinent factors affecting peer grouping costs.

(n) (1) An audit adjustment or adjustments, either specific to an adult day health care center or by peer grouping, reflecting the difference between reported and audited costs and participant days for field audited centers, shall be applied to all adult day health care centers for purposes of establishing the core services reimbursement rate and the reimbursement limit for the following rate year. Audit adjustments shall include all of the following:

(A) The results of settled appeals. The department shall consider only the findings of audit appeal reports that are issued more than 180 days prior to the beginning of the new rate year.

(B) In the case of peer grouping audit adjustments, audited costs shall be modified by a factor reflecting share-of-cost overpayments and share-of-cost underpayments.

(C) The results of federal audits, when reported to the state, shall be applied in determining audit adjustments.

(D) (i) An adjustment or adjustments to reported costs of adult day health care centers shall be made to reflect changes in state or federal laws and regulations that would affect those costs, including increases in the minimum wage or increases in minimum staffing requirements.

(ii) The costs described in clause (i) shall be reflected as an add-on to the new rate or rates.

(iii) To the extent not prohibited by federal law or regulations, add-ons to the rate or rates shall continue until those costs are included in cost reports used to set the new rate or rates.

(2) Adjusted costs shall be divided into categories and treated as follows:

(A) Fixed or capital-related costs shall include costs that represent depreciation, leases and rentals, interest, leasehold improvements, and other amortization. No update shall be applied.

(B) Property taxes, where identified, shall be updated at a rate of 2 percent annually.

(C) Labor costs, which shall be defined as a ratio of salary, wage, and benefits costs to the total costs of each adult day health care center, shall be updated based upon the labor study conducted by the department and using industry-specific wage data as reported by the adult day health care centers. The separately billable services shall be updated by applying the median market-based rate specific to the specialty service category.

(D) All other costs shall include all other costs less fixed or capital-related costs, property taxes, and labor costs. This cost category shall be updated using the California Consumer Price Index.

(3) Prior to the implementation of this methodology, the department shall take measures to ensure appropriate training of state audit staff.

(o) The department shall provide updates on the rate methodology to the appropriate fiscal and policy committees of the Legislature. The appropriation for services paid under this rate methodology shall be included in the annual Budget Act.

(p) Adult day health care centers may appeal findings that result in an adjustment to the rate or rates pursuant to Section 14171 and to Article 1.5 (commencing with Section 51016) of Chapter 3 of Division 3 of Title 22 of the California Code of Regulations.

(q) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of a provider bulletin or similar instruction without taking regulatory action. By August 1, 2015, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) The department shall notify and consult with interested stakeholders in implementing, interpreting, or making specific the provisions described in this section.

(r) The department shall implement this section only to the extent that federal financial participation is obtained.

(s) The department may file a state plan amendment to implement the requirements of this section. Immediately upon filing any such state plan amendment, the department shall provide the fiscal committees of the Legislature with a copy of the state plan amendment.

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