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INITIAL STATEMENT OF REASONS

CALIFORNIA CODE OF REGULATIONS

Title 22, Division 7, Chapter 10: Health Facility Data – Expanding Managed Care Payer Categories

Sections 97019 and 97041

I. BACKGROUND INFORMATION

The Health Data and Advisory Council Consolidation Act (the Data Act), Health and Safety Code §128765 – 128810, requires that the Department of Health Care Access and Information (HCAI) establish uniform systems of accounting for all California health facilities licensed pursuant to Chapter 2 of Division 2 of the Health and Safety Code. As part of its responsibility to maintain a uniform system of accounting, HCAI is obligated to update that system to meet the current needs of facilities using the system. Pursuant to Health and Safety Code (HSC) §128735, long-term care (LTC) facilities shall file annual financial disclosure reports with HCAI. The report is known as the LTC Integrated Disclosure and Medi-Cal Cost Report (LTC Report), which also serves as the Medi-Cal Cost Report for those facilities, pursuant to HSC §128730.

HCAI's *Accounting and Reporting Manual for California Long-Term Care Facilities*, Second Edition (LTC Manual) is incorporated by reference in current regulation. The LTC Manual establishes the accounting system health facilities must use and details methods for completing and filing the required report. Section 4001 of the Manual states that every skilled nursing and intermediate care facility required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code, must complete and file this report. If Medi-Cal providers, the report must also be completed and filed to satisfy the requirements of Section 51511.2, Title 22, California Code of Regulations.

For several decades, Medicare and Medi-Cal have been transitioning away from a Fee-for-Service (FFS) payment and delivery system to a Managed Care system. Under the FFS system, beneficiaries could see any provider who accepts Medicare or Medi-Cal, and providers were reimbursed for each individual service or visit. Under Managed Care, health plans and insurers are contracted to deliver benefits to members in exchange for a monthly member fee.

Due to this transition, facility representatives, along with patient and labor advocates have asked that HCAI expand the managed care payer category to more accurately represent what is seen in the LTC industry. Currently, the LTC system of accounts includes five payer categories:

1) Medicare,
2) Medi-Cal,
3) Self-Pay,
4) Managed Care, and
5) Other Payers

This system can be confusing when reporting certain payers, like Medicare Managed Care. Although it is specified in the Manual, facilities often report this incorrectly in the Medicare payer category when it should be in the Managed Care category. To increase transparency and accuracy in reporting, HCAI is opting to update our system of accounts. The update will expand the number of payer categories from five to eight including:

1) Medicare FFS,
2) Medicare Managed Care,
3) Medi-Cal FFS,
4) Medi-Cal Managed Care,
5) Commercial Coverage FFS,
6) Commercial Coverage Managed Care,
7) Self-Pay, and
8) Other Payers

1) Medicare FFS includes patients covered under the Medicare Program. These patients are primarily seniors and people with disabilities. It does not include those covered by a managed care plan funded through Medicare.

2) Medicare Managed Care includes patients covered by a managed care plan that is funded through Medicare.

3) Medi-Cal FFS includes patients that are enrolled in Medi-Cal – California's Medicaid program for low-income people. It does not include those covered by a managed care plan funded through Medi-Cal.

4) Medi-Cal Managed Care includes patients covered by a managed care plan that is funded through Medi-Cal.

5) Commercial Care FFS includes patients who have private coverage that is employer/employment-sponsored or privately purchased. This includes Covered California plans. It does not include coverage funded by Medicare, Medi-Cal, a county, Workers' Compensation, or other government programs.

It does not include patients enrolled in a managed care plan funded through Commercial Coverage.

6) Commercial Coverage Managed Care includes patients enrolled in a managed care plan funded by Commercial Coverage.

7) Self-Pay includes patients who are financially responsible for their own care and who are not covered by a third-party payer program.

8) Other Payers includes all patients who are not included in one of the listed categories.

HCAI is proposing to adopt regulations to implement the new payer categories and incorporate other minor clarifications and corrections into the HCAI LTC uniform system of accounts via the LTC Manual to stay relevant with the changing healthcare industry to become effective for reporting periods ending on or after January 1, 2024.

II. THE PROBLEM TO BE ADDRESSED

New regulations are required to add the new payer categories into the LTC Manual to stay abreast of changes in the health care industry.

The current accounting and reporting system requirements do not provide the necessary guidance or information from which meaningful decisions can be made regarding managed care. Further, the current reporting requirements limit the disclosure of payer categories, and some definitions and instructions are out of date.

III. THE PURPOSE AND BENEFITS OF THIS REGULATORY ACTION

The underlying objective of the Long-Term Care reporting program is to provide the public, the long-term care industry, and state policy makers accurate, uniform, and objective information regarding the revenues, expenses, assets, liabilities, equity, capacity, and utilization of licensed California long-term care facilities. As public information, this data will continue to be available to officials at all levels of state and local government for their use in formulating and evaluating health system policies and in managing governmental health delivery systems. This data will also be available to health care consultants, employers, insurers, organized labor, and other health care purchasers who may use the information to make informed decisions in today's health care market. Finally, the data is available to health service providers who may use the information for health facility management and strategic planning purposes.

Specifically, this regulatory action will address this issue by expanding Managed Care payer categories in the chart of accounts to separately account and report patients

covered by managed care plans and those patients whose care is funded through a Commercial Coverage plan.

HCAI is incorporating by reference updated software specifications for software used to prepare the annual reports for submission.

IV. NECESSITY

Section 97019, of Title 22 of the California Code of Regulations relating to the *Accounting and Reporting Manual for California Long-Term Care Facilities*, Second Edition must be amended to update effective dates and instructions for reporting the expanded payer categories. The regulations are necessary to interpret and provide specificity regarding the various payer categories to ensure consistent, uniform accounting across California long-term care facilities.

Section 97041, of Title 22 of the California Code of Regulations must also be amended to update references to the Instructions and Specifications for Developing Approved Software to Submit the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report.

V. THE SPECIFIC PURPOSE OF EACH AMENDMENT

§97019. Accounting and Reporting Manual for California Long-Term Care Facilities

HCAI proposes amendments to the *Accounting and Reporting Manual for California Long-Term Care Facilities*, Second Edition to instruct long-term care facilities on how to report the new payer categories and implement the updated chart of accounts. The purpose of the proposed changes to §97019 is to incorporate by reference the revised LTC Manual and corresponding effective dates.

The effective date of proposed amendments will be the applicable effective date pursuant to Government Code §11343.4. The LTC Manual, as amended April 2020, will remain in effect for report periods prior to January 1, 2024.

§97041. Report Procedures

HCAI proposes the following changes:

- Revise the reporting procedures to instruct long-term care facilities on how to report the new payer categories and implement the updated chart of accounts.
- Revise the Instructions and Specification for Developing Approved Software for Submitting the annual Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report to enable facilities to report the additional payer categories effectively.
- Revise the method of obtaining approval to distribute software from regular mail to email.

AMENDMENTS TO THE ACCOUNTING AND REPORTING MANUAL FOR CALIFORNIA LONG-TERM CARE FACILITIES, SECOND EDITION

ACCOUNTING PRINCIPLES AND CONCEPTS §1000

Amortization §1030
Minor correction in a formula in the second to last paragraph – changed a parenthesis to a slash.

Contractual Adjustments §1061
Added instructions to utilize subaccounts to differentiate between Fee-for-Service and Managed Care Contractual Adjustments.

Accounting for Managed Care and Other Contracts §1062
Corrected typo in first paragraph citing three methodologies when should have cited two.

Updated definitions for “Health Maintenance Organization (HMO)” and “Member”.

Updated Account Names and Account Numbers in example journal entries to be consistent with revised Chart of Accounts.

Other Deductions from Revenue §1063
Updated Account Number in example journal entry to be consistent with revised Chart of Accounts.

Timing Differences §1150
Updated Account Name in example journal entry to be consistent with revised Chart of Accounts.

Depreciation §1160
Updated edition of “Estimated Useful Lives of Depreciable Hospital Assets” from 1988 to 2018.

Consolidations §1320
Updated reference of resource for consolidations of related organizations from “ARB No. 51 and FASB Statement No. 94 to “Accounting Standards Codification (ASC) 810-10”.

CHART OF ACCOUNTS §2000

Revised the patient revenue subclassifications in the LTC Manual’s Chart of Accounts to accommodate the expanded Managed Care payer categories and the addition of the Commercial Coverage payer category.

The numeric coding system in the Chart of Accounts uses six digits. Account numbers include four digits to the left of the decimal point, which identify the primary account classification, and two digits to the right which identify secondary account classifications (subclassifications). The classifications and subclassifications for patient revenue accounts are being revised to accommodate the expanded payer categories.

Statement of Income Account Numbers §2012
Updated examples of revenue and expense account names and numbers to be consistent with revised Chart of Accounts.

Deductions from Revenue §2210.3
Replaced Contractual Adjustments – Managed Care with Contractual Adjustments – Commercial Coverage to be consistent with other account changes. These proposed changes will make deductions from revenue reportable by payer classification on the LTC Report.

Subclassifications of Patient Service Revenue Accounts and Deductions From Revenue §2230
Updated for proposed amendments to the Chart of Accounts.

ACCOUNT DESCRIPTIONS §3000

Deductions from Revenue §3210.3
Replaced Contractual Adjustments – Managed Care with Contractual Adjustments – Commercial Coverage to be consistent with other account changes.

Subclassifications of Patient Service Revenue Accounts and Deductions From Revenue §3230
Revised names and numbers for Patient Service Revenue Accounts to be consistent with the chart in Section 2230 and other proposed amendments to the Chart of Accounts.

REPORTING REQUIREMENTS AND INSTRUCTIONS §4000

The specific purpose is to revise the LTC Manual, as applicable to the revised reporting requirements for the expansion of Managed Care payer categories and addition of the Commercial Coverage payer category. Specific updates are listed by section.

Page 10.4 – Adjustments to Trial balance Expenses and Related Party Transactions §4020.3.2
Corrected minor typo for Column 10 instructions.

Page 10.1 – Expense Trial Balance Worksheet §4020.4
Revised instruction for Column 13 to include Page 10.4.

Page 4.1 – Facility Patient Days by Payer §4020.5

This report page is being updated to accommodate the expansion of Managed Care payer categories and the addition of the Commercial Coverage payer category. This LTC Manual section is updated to provide guidance and instructions for reporting the new categories. Payer Categories expanded from five categories to eight:

Current Payer Categories

1) Medicare is a Federal third-party reimbursement program administered by the Centers for Medicare and Medicaid Services that underwrites the medical costs of persons 65 and over, and some qualified persons under 65. Data related to Medicare patients enrolled in health maintenance organizations (HMOs) should not be reported in the Medicare payer category but are part of the "Managed Care" payer category.

2) Medi-Cal is a Federal-State funded, State operated and administered, Medicaid program which provides medical benefits for certain low-income and needy persons. Data related to Medi-Cal patients enrolled in HMOs are not included in the Medi-Cal payer category but are part of the "Managed Care Payer" category.

3) Self-Pay includes patients who are financially responsible for their own care and who are not covered by a third-party payer program.

4) Managed Care includes patients who belong to groups (HMOs, PPOs, or others) that have a contractual relationship with the facility. Managed Care includes patients enrolled in managed care plans funded by Medicare, Medi-Cal or other government programs, as well as patients enrolled in commercial managed care programs.

5) Other Payers includes all payers other than Medicare, Medi-Cal, Managed Care and Self-Pay.

Proposed Payer Categories:

1) Medicare FFS includes patients covered under the Medicare Program. These patients are primarily seniors and people with disabilities. It does not include those covered by a managed care plan funded through Medicare.

2) Medicare Managed Care includes patients covered by a managed care plan that is funded through Medicare.

3) Medi-Cal FFS includes patients that are enrolled in Medi-Cal – California's Medicaid program for low-income people. It does not include those covered by a managed care plan funded through Medi-Cal.

4) Medi-Cal Managed Care includes patients covered by a managed care plan that is funded by Medi-Cal.

5) Commercial Coverage FFS includes patients who have private coverage that is employer/employment-sponsored or privately purchased. This includes Covered California plans. It does not include coverage funded by Medicare, Medi-Cal, a county, Workers' Compensation, or other government programs.

6) Commercial Coverage Managed Care includes patients covered by managed care plans whose care is funded through Commercial Coverage.

7) Self-Pay includes patients who are financially responsible for their own care and who are not covered by a third-party payer program.

8) Other Payers includes all patients who are not included in one of the listed categories.

Page 4.2 – Facility Patient Days by Payer §4020.6

Updated page to accommodate expansion of payer categories.

Updated page to accommodate reporting Deductions from Revenue by payer category.

Page 4.3 – Other Census and Revenue Information §4020.7

Updated reference to Page 4.1 in calculation of facility Occupancy Rate on Line 60.

Updated references to Page 4.1 in instructions for Lines 120, 150, and 175.

Page 11 – Allocation of Indirect Costs to Direct Costs Center – Health Care Only §4020.8

Updated references to Page 4.1 in instructions for Line 105.

Page 13 – Computation of Ancillary Services Costs per Patient Day – (Special Care Program Contract Providers, Only) §4020.9

Updated references to Page 4.1 in instructions for Column 6, Line 105.

Updated references to Page 4.2 in instructions for Column 2.

Page 8 – Statement of Income – General Fund §4020.10

Updated references to Page 4.2 in instructions for Lines 5, 7, 10 and 15.

Page 1 – General Information and Certification §4020.21

Added instruction to complete Administrator compensation on Page 10.4.

APPENDIX B – "Glossary"

Added definitions for "Fee-for-Service" and "Managed Care"

Reporting Forms §4100

No changes have been made to this section. The reporting forms have been updated to incorporate changes described in §2000 and §4000.

Added “Hospice” as a License Category on Page 2.1 for increased accuracy in reporting.

Revised Pages 4.1 and 4.2 to accommodate the addition of Fee-for-Service and Managed Care payer categories.

Instructions and Specifications for Developing Approved Software to Prepare the California Integrated Disclosure and Medi-Cal Cost Report

Added specifications for Pages 4.1 and 4.2 to be consistent with changes in the reporting forms as well as other minor changes resulting from the added specifications (i.e., changing line numbers in calculations).

VI. ECONOMIC IMPACT ANALYSIS

New regulations are required to revise the Chart of Accounts in the LTC Manual to accommodate the expanded payer categories.

The proposed regulations impose only minor additional reporting on any businesses, organizations, or individuals. The accounting and tracking systems will need to be updated to accommodate the new payer categories.

These changes are anticipated to be beneficial to the general public – while there may be minor initial implementation costs, increasing the transparency of healthcare payment delivery systems will increase the usefulness of the annual disclosure report and also be helpful for Medi-Cal auditors in making future determinations and recommendations.

Therefore, HCAI concludes that:

(1) this regulatory action will not create jobs within the state;

(2) this regulatory action will not eliminate jobs within the state;

(3) this regulatory action will not create new businesses;

(4) this regulatory action will not eliminate existing businesses;

(5) this regulatory action will not affect the expansion of businesses currently doing business in the state; and

(6) The benefits of the regulations to the health and welfare of California residents, worker safety, and the state's environment are to achieve the goals of HSC §128734 by adding more detail to the Chart of Accounts.

VII. EVIDENCE SUPPORTING FINDING OF NO SIGNIFICANT ADVERSE ECONOMIC IMPACT ON ANY BUSINESS

HCAI has determined that adoption of the proposed regulations would not have an adverse economic impact on any business in the State of California because the financial impact of proposed regulations will be minor, if any. There is no anticipated cost impact to approximately 1,300 health facilities because these facilities are already required to submit the annual Long-Term Care Integrated Disclosure & Medi-Cal Cost Report and updating their Chart of Accounts is a normal cost of doing business. Facilities may incur a minor, one-time cost of approximately $6,000 (80 hours at $75 per hour) to update their systems to collect, track and report the additional information.

VIII. TECHNICAL, THEORETICAL, OR EMPIRICAL STUDY, REPORTS, OR SIMILAR DOCUMENTS RELIED UPON

None.

IX. CONSIDERATION OF ALTERNATIVES

No reasonable alternatives have been identified by HCAI or have otherwise been identified and brought to its attention that would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed action or would be more cost-effective to affected private persons and equally effective in implementing that statutory policy or other provision of law.