AB1629

Workforce Training Employer's Toolkit

Produced by the

MILKEN INSTITUTE

with Funding from

CALIFORNIA HEALTHCARE FOUNDATION

Acknowledgments

This work was supported by a grant from the California HealthCare Foundation, Oakland, California.

With a Web site at www.chch.org, CHCF is an independent philanthropic organization committed to improving the way health care is delivered and financed in California and helping consumers make informed health-care and coverage decisions. Formed in 1996, its goal is to ensure that all Californians have access to affordable, quality health care.

The Milken Institute is an independent economic think tank.

Its mission is to improve the lives and economic conditions of diverse populations in the U.S. and around the world by helping business and public policy leaders identify and implement innovative ideas for creating broad-based prosperity.

The Milken Institute was founded in 1991, and is headquartered in Santa Monica, California

The Authors

Michael Bernick is a Senior Fellow of the Milken Institute, and counsel with the San Francisco law firm of Sedgwick, Detert, Moran & Arnold. From 1989 to 2004 he served as the Director of California's Employment Development Department. He has over 25 years of employment and training experience in California. From 1979 to 1986, Bernick worked with the San Francisco Renaissance Center, an inner city job training and economic development agency. Since 1986 Bernick has continued his involvement in the employment field as a board member of numerous training agencies, including the Ella Hill Hutch Community Center, Parents of Success, Youth for Service and the Mission Reading Clinic. He was a board member of BART, the regional rail transit agency for eight years and is the author of more than 20 articles and four books on employment and economic development. Bernick earned his law degree at the University of California, Berkeley.

Kenneth Merchant is a Program Associate of the Milken Institute, and is a workforce development and education consultant for the long term health care professions. Between 1999 and 2005 he served as the Executive Director of the Quality Care Health Foundation. In this capacity he developed and managed over $11 million in workforce training and career ladder programs funded by the state and federal governments and long-term care employers. He is a graduate of the University of California, Davis, and is an appointed member of the California Board of Vocational Nurses and Psychiatric Technicians.

Contents

Introduction

AB1629 provides employers with the means to make career ladder professional development programs possible. The purpose of this Tool Box is to provide you with the information you need to translate the opportunity presented by AB1629 into results that will improve your quality of care and your bottom line.

It has always made sense to invest in professional development for Long-Term Care workers. This is a field that is comparatively easy to enter, that pays a decent starting wage, where jobs are readily available.

When employers help their employees with professional development it pays big rewards. The increased skills and loyalty that employees gain result in higher levels of patient care, cost saving innovations and lower levels of turn over.

The California Association of Health Facilities recognized these rewards in 2000, when it adopted its *Career Ladder Concept*, a document that's stated goal was to:

> *"Create a seamless career path that allows a worker to start with an Employer as a CNA, and advance professionally to become a Licensed Vocational Nurse, without ever having to stop working, or leave their original Employer."*

The problem with investing in professional development has always been financial. In a profession where margins are tight it just hasn't been practical to fully invest in the programs necessary to implement the *Career Ladder Concept*.

AB1629 has changed this. By introducing facility-specific Medi-Cal reimbursement rates it has removed a major disincentive to investing in training—investments in training will be reflected in a higher future rate, not in going over the regional median rate. It has also introduced a new Caregiver Training reimbursement category that will be handled as a direct pass-through of Medi-Cal's share of cost.

AB1629 Background

AB1629 was signed on September 29, 2004. It was the result of a collaboration between legislators, employers and workers. AB1629is scheduled to *sunset* on July 31, 2008, which means that if it is not re-authorized in the 2008-2009 budget then it will end on that date.

AB1629 changed the manner in which Skilled Nursing Facilities are reimbursed for services by Medi-Cal. Specific changes of note are:

- Replaced the flat rate reimbursement system with a facility-specific rate system—Under the old system SNFs were reimbursed based on the regional median cost for Medi-Cal services. This created a system in which there was a disincentive to investments in training or professional development over the state mandated minimums. Programs such as the CNA

Certification course can be expensive, and if they raised costs above the regional median they were effectively un-reimbursed.

The new facility-specific rate system will utilize an individual SNF's actual costs as the basis for determining their Medi-Cal reimbursement rate. This creates an incentive to invest in professional development training. Dollars spent up-front for training will be reflected in a higher reimbursement rate in the future.

- Created a new Caregiver Training reimbursement category—A number of specific areas of professional development training qualify as Caregiver Training programs. These programs are reimbursed as a direct pass-through of Medi-Cal's share of cost.
- Created a Direct Labor Costs reimbursement category—The largest potential costs associated with professional development training are employee wages during training, and training program tuition costs. Under AB1629 both of these areas are now covered under the definition of Direct Labor Costs.

Professional Development Need in Skilled Nursing Facilities

The most critical professional development needs, and the greatest opportunities lie with the direct patient care staff. These are the professions for which AB1629 training funds are primarily intended.

Certified Nurse Assistants (CNA)—There is an ongoing need for a steady stream of new CNAs. Turnover rates continue to be high, despite reduced competition from the acute care health segment.

SNF's retain the ability to train their own CNAs, though most are now trained by outside agencies. Recent pilot projects have indicated that facility-based CNA certification training offers potential advantages in bonding employees to their employers, which can lead to improved performance and reduced turnover.

Paraprofessional career ladder programs are certification programs for CNAs that allow them to do more, while continuing to work within the CNA scope of practice. The most commonly utilized paraprofessional certification category is the Restorative CNA. Formal CNA career ladder programs have been demonstrated to improve employee morale and loyalty to their employers. Such programs also offer the potential to provide a screening tool for candidates for advancement into nurse training programs.

Licensed Vocational Nurses (LVN)—LVN is a serious shortage area for SNF employers. CNAs make good candidates for LVN training programs, provided they can prepare themselves with the background education required to qualify, and that they have financial assistance and community support in their efforts. SNF employers have a 20+ year history of successfully assisting CNAs become LVNs.

Registered Nurses (RN)—RN is probably the most critical shortage area for SNF employers. A tight job market makes it difficult to recruit new RNs and intense pressure from acute care employers makes it hard to hold on to the ones you have.

How AB1629 Can Help You Meet Training Needs

By providing reimbursement for training expenses AB1629 gives employers options that they never had before. However, it is an area that should be approached with caution. Employers will still be responsible for paying their costs up front, with the understanding that they will be reimbursed through a higher Medi-Cal rate at a later date.

Assurance of reimbursement—The Milken Institute has identified a variety of official sources that assure that employers will be reimbursed for expenses incurred for professional development training.

- **Statutory Guidance**—These provide the legal basis for reimbursement of workforce development training through California state law. These are:
  - AB1629 (Appendix 1)
  - Governor Schwarzenegger's signing message for AB1629 (Appendix 2)
  - The State Medicare Plan Amendment, which constitutes regulations for AB1629 (Appendix 3).
- **Policy Guidance from State and Federal Governments**
  - Letter, dated September 5, 2006, from Stan Rosenstein, DHS Deputy Director for Medical Care Services (Appendix 4).
  - E-mail, dated June 6, 2006, from Cecilia Keiser, DHS Medical Care Services (Appendix 5).
  - DHS Medi-Cal Bulletin # 352, dated July 2006 (Appendix 6).
  - 42CFR413.85, federal regulatory guidance for reimbursement of Caregiver Training (Appendix 7).

Reimbursement Categories—There are two general categories in to which AB1629 professional development training will fall:

- **Caregiver Training Costs**—This is a new category, intended to pay for training employees for critical skills that are required to provide quality care, either because of state regulations or due to common practice, with training linked to a formal certification.. It covers training costs only, such as tuition and
  - It is paid as a pass-through of 100% actual cost, subject to Medi-Cal's proportional costs.
  - An example of a reimbursable Caregiver Training Cost is CNA Certification, when it is conducted in-house by a SNF.

- **Direct Labor and Benefit Costs**—This category covers most professional development training that does not qualify as Caregiver Training.
  - It is counted in the Cost Report at 100% of actual cost, subject to a cap of 90th percentile of the peer group for direct labor cost.
  - Wages paid to employees while they are in training are reimbursable under this category.
  - Benefits provided to employees are reimbursable under this category. This specifically includes benefits such as tuition costs for training programs such as nursing schools, as well as wages paid to employees while they are in outside patient-care related training programs.
- **In-Direct Non-Labor Costs**—This category includes payments to training consultants, payments for training supplies and other costs related to training that do not fall in the direct labor costs category.
  - It is counted in the Cost Report at 100% of actual cost, subject to a cap of 75th percentile of the peer group for in-direct non-labor cost.
  - Examples include the non-labor costs incurred when nursing students conduct clinical rotations in a SNF, or payments to outside training vendors for training conducted in the facility.

Determining the right Reimbursement Category—On June 6, 2006, CAHF received a written response from Cecilia Keiser (DHS-MCPD-RDB). This response is presented in its entirety as Appendix 5. In her response Ms. Keiser laid out the following conditions for reimbursement under the Caregiver Training Category:

- "providers should rely on the OSHPD and federal guidelines to determine if their program meets those guidelines"

  note: OSHPD and federal guidelines are encompassed by 42CFR413.85, *Principles of Reasonable Cost Reimbursement; Payment for End-stage Renal Disease Services; Prospectively Determined Payment Rates for Skilled Nursing Facilities*
- "..formal education program required for a state license and the program has to be nationally or state licensing accredited for the basic nursing provider category.."
- "..education program organized by the facility, or where the facility hires an outside vendor to conduct the training.."
- "Only direct costs attributable to the program count."
- "The occupational specialty should be one that is widely recognized and preferably one that has an independent certifying body."

The following categories of payment were specifically excluded from payment under Caregiver Training:

- "...continuing education programs that do not lead to a required license or certification..."
- "Wages...as those are direct labor."
- "Paying the tuition for an employee to go to school..."
- "Paying for an employee's time while going to school..."
- "...training for non provider categories..."

Ms. Keiser's message clarified the basis under which employee benefits could be utilized to achieve Medi-Cal reimbursement for patient-care related professional development training:

- "Paying the tuition for an employee to go to school is an employee benefit cost."
- "Paying for an employee's time while going to school is also a benefit cost."

Based on this guidance, and on our review of 42CFR413.85, it is our belief that the following interpretations can be applied to training reimbursement questions.

How the Reimbursement process will work—Employers will complete the same basic cost report as they did prior to AB1629. They will also be required to complete a supplemental report identifying caregiver training costs.

- All costs associated with their professional development training programs should be reported and appropriately coded.
- Caregiver Training costs are a direct pass-through, and will be reflected in the next Medi-Cal rate adjustment applicable to the filed cost report and supplemental schedule.
- All other costs will be included in the regular rate-setting process and will be reflected in the Medi-Cal rate consistent with the time period of the cost report and supplemental schedule.

Review Medi-Cal Reimbursement Bulletin #352 (Appendix 6) for additional details.

Program Name	Training Cost	Cost Report/ Reimbursement Category	Basis for Assumption
Professional Development for Direct Care Staff			
Registered Nurse (RN) or Licensed Vocational Nurse (LVN)	Tuition and program costs, paid directly by employer, or reimbursed to employee	Direct Labor Costs	• Results in certification required by state statute • Tuition and training wages categorized as "Employee Benefit"
	Employee wages paid during training	Direct Labor Costs	
Director of Nursing Certification	Tuition/registration costs	Direct Labor Costs	• Employee benefit • Curriculum does not have national accreditation • Training is not required by state statute
	Employee wages paid during training, travel costs, per-diem and lodging costs	Direct Labor Costs	
Director of Staff Development Certification	Tuition/registration costs	Caregiver Training	• Curriculum accredited by State of California • Certification is required by state statute
	Employee wages paid during training, travel costs, per-diem and lodging costs	Direct Labor Costs	
Facility-based CNA Training Program	Training program costs, including materials and outside consulting support	Caregiver Training	• National and State accredited curriculum • Results in certification required by state statute
	Student and DSD wages during training	Direct Labor Costs	
Restorative CNA (RNA)	Training program costs, including materials and outside consulting support	In-Direct Non-Labor Costs	• Curriculum has state accreditation, but does not yet have national accreditation • Training is not required by state statute
	Employee wages during training, travel costs, per-diem, lodging	Direct Labor Costs	
Senior CNA (SNA)	Training program costs, including materials and outside consulting support	In-Direct Non-Labor Costs	• Curriculum has state accreditation, but does not yet have national accreditation • Training is not required by state statute
	Employee wages paid during training, travel costs, per-diem and lodging costs	Direct Labor Costs	
Certified Memory Impairment Specialist	Training program costs, including materials and outside consulting support	In-Direct Non-Labor Costs	• National and State accredited curriculum • Training is not required by state statute
	Employee wages during training, travel costs, per-diem, lodging	Direct Labor Costs	

Program Models You Can Implement Rapidly

The Milken Institute has identified a variety of professional development training programs that already exist, and can be implemented rapidly by employers. These include:

CNA Certification Course—SNF employers have the opportunity to offer the CNA Certification Course in their facility. This training qualifies as Caregiver Training, and is subject to a direct pass-through of the Medi-Cal share of cost other than labor costs.

- CNA Certification Courses are required to include a minimum of 160 hours of training (60 classroom, 100 clinical). In reality, most programs seem to run closer to 200 hours.
- Employers must be in good-standing with DHS. One common penalty that DHS imposes for survey related issues is a 2-year suspension of a facility's ability to offer CNA training.
- Programs must be approved by DHS Licensing & Certification Branch. The approval process covers the curriculum to be used, the training schedule, the physical space used for training and the qualifications of the DSD. There are three CNA curricula in use that automatically meet the DHS review standard, one offered by the American Red Cross, one by the Community College System (NATAP), and one offered by the Quality Care Health Foundation.
- In general any Director of Staff Development can qualify to teach a CNA Certification Course. In reality a good number of DSDs cannot manage this task and meet their other DSD duties. It is a common practice to assign additional staff to assist the DSD with teaching CNA Certification Courses. In some cases this is another nurse, in other cases a CNA.
- For SNFs that have not offered the CNA Certification Course for an extended period, and who believe that they need assistance, there are consulting services available that can help. Such services offer assistance with selecting curricula, setting up training sites and record-keeping systems and earning DHS approval. In some cases these consultants will also remain on site to assist the DSD through training the first class of CNAs.

Certified Memory Impairment Specialist (CMIS)—This is a professional certification offered by the National Memory Impairment Institute (NMII). It is intended to train direct caregivers with the tools to recognize behaviors that are due to memory impairment issues (such as Alzheimer's or dementia), and to respond in ways that de-escalate the situations that can arise. This program was developed initially for emergency room technicians and medical first-responders. It has been used in the Long-Term Care setting since the late 1990s.

- CMIS training takes approximately 8 hours, and can either be taught by an instructor from NMII, or by a facility's own DSD. In order to qualify as a trainer the DSD must go through a 16 hour certification course taught by NMII.

Restorative CNA (RNA)—RNA is a widely recognized job title within SNFs, but CNAs typically do not receive certificate training in this area. Most RNAs are trained on an OJT basis by therapists or nursing staff. Between 2002 and 2004 the Quality Care Health Foundation (QCHF) developed a formal certification program for RNA.

- The formal RNA program developed by QCHF requires 16 hours of training. Training is conducted by a team consisting of an Occupational Therapist, a Physical Therapist, a Speech Pathologist and a Nurse. This program results in the graduate receiving a nationally recognized certificate and they are entered into a statewide database.
- All RNA programs, whether formal or OJT, qualify for Medi-Cal reimbursement. Labor and benefits costs fall under the Direct Labor category, while other costs fall under the In-Direct Care Non-Labor category. The QCHF RNA curriculum is currently under review by a national organization. If adopted by that organization the QCHF programs could qualify as Caregiver Training.

CNA to Licensed Vocational Nurse (LVN)—Long-Term Care employers have a history dating back to the 1980s of providing direct assistance to their workers who seek to become LVNs. In the early 2000s additional pilot programs were developed in this area. As a result there are a rich variety of options for employers who wish to utilize AB1629 resources to assist their workers to become LVNs.

- LVN courses require approximately 1,500 hours of training time to complete. For a full-time student this can, in theory, be done in about one year. In reality most LVN courses are designed for students who work part-time, and take between 18 and 24 months to complete.
- CNA to LVN courses are LVN programs that require having the CNA as a pre-requisite for admission.
- LVN courses can only be taught by organizations licensed by the Board of Vocational Nursing and Psychiatric Technicians. There are currently 113 accredited LVN programs, with more being approved on an ongoing basis. These programs are typically offered by Community Colleges, Adult Schools, High School ROP programs, or for-profit Private Post-Secondary Schools.
- Employers have the option of funding training at any LVN program for which their employee can be accepted. Based on DHS guidance, tuition costs and wages for the employee while in school are considered employee benefits and are reimbursable under the wages and benefits category.
- Employees wishing to become LVNs are responsible for meeting all admission criteria for the courses to which they apply. This includes demonstrating math and English language skills and completing all required pre-requisite training classes. In some cases LVN programs have extensive waiting lists, and employees must go through the normal selection process.
- Employers can help their employees bypass waiting lists in one of two ways. They can work directly with Private Post-Secondary Schools, which will usually require that the employer

either make, or guarantee payment of program costs. Employers can also enter into partnership programs with other employers and/or workforce development agencies, allowing them to "purchase" LVN classes. In these cases the normal selection process does not apply, and employers can assist qualified employees in receiving training slots.

- Partnership programs typically leverage resources from employers, workforce development agencies and the training organization. In general, employers make financial contributions toward tuition costs, pay wages to their employees while they are in training, and provide a variety of "in-kind" services. In exchange the other partners provide assistance with employees completing pre-requisite course work, they provide limited supportive services during training, and preferred access to classroom slots. Since employers pay fewer direct costs under these programs it allows them to train a larger number of nurses for the same up-front outlays. AB1629 is supportive of such partnership programs.

Potential for New Program Models—The programs listed above are examples of existing models that can be adopted quickly. The potential exists to develop a wide range of additional professional development training models using AB1629 to provide all or part of the funding. Prime candidates include LVN to RN upgrade projects, "re-entry" programs for people who hold nursing or advanced medical licenses in other countries who are unable to work in those fields in the US or whose US licenses have lapsed, or a wide range of paraprofessional career ladder programs for people currently working as CNAs.

Training Partnerships and Leveraging Resources

As previously mentioned, there can be major advantages to entering into training partnerships. Such programs typically involve groups of SNFs working together. Sometimes this can be done by a "multi" employer bringing together facilities under their control. In other cases the group can be organized through a group like a local CAHF or Aging Services of California chapter.

The following is a list of potential training partners:

Local Workforce Investment Boards (WIB)—Federal employment assistance and job development funds are distributed and controlled by Local Workforce Investment Boards. There are 50 WIBs in California, each responsible for services in a distinct geographical area. Most are based on counties, though some larger cities have opted out of their county system and have established their own WIBs (there are 7 separate WIBs in LA County). WIBs work in partnership with, but independently from the state Employment Development Department.

- WIBs have limited funding they can apply for programs such as LVN courses, typically through a process they refer to as contracted training. This requires employers to pay a minimum of 50% of the tuition costs incurred for the training.
- WIBs can be excellent partners in organizing and managing partnership programs, taking much of the administrative burden off of employers. For example, when "buying classes" the WIBs can serve as the contracting agent with the training program.
- WIBs control a wide range of "supportive services" that can help employees succeed in programs such as LVN. These range from career counseling and guidance up to assistance with some expenses (child care, transportation).
- In some cases WIBs can help access additional funding from other sources that can help offset employer costs for training.

Employment Training Panel (ETP)—ETP manages the state Employment Training Fund, a special fund that collects money from the Unemployment Insurance taxes paid for workers by their employers. ETP uses these funds to assist employers to pay for professional development training designed to make them more competitive, and to help keep jobs in California.

- Only employers who pay Unemployment Insurance for their workers can qualify for ETP funds.
- ETP rules and contract requirements can be challenging. It is best to seek professional assistance in developing and managing ETP related projects. "Multis" typically have the resources and staffing to successfully manage ETP contracts. Potential partners include WIBs, or trade associations such as CAHF or Aging Services of California. There are also consultants available who will assist in developing and administering ETP contracts.
- ETP's rules were changed recently in order to make it easier for them to fund nursing programs. They have approved a number of contracts for CNA to LVN programs since the beginning of 2006. To date all such programs have been partnerships involving multiple employers and either a WIB or a trade association.

Community College System—Community Colleges offer a wide variety of resources that could be useful to an employer seeking to develop professional development training. These include:

- Existing vocational education programs that might be useful to the employer. Sending workers to attend Community College classes in areas that impact the quality of patient care are reimbursable.
- Courses offered by Community Colleges through their regular course catalog are required by law to be open to the public. For nursing programs, where there are already far more applicants than available slots this means that schools must use a selection process to place students. Typical systems used include either setting up a waiting list, where candidates are enrolled in the order in which they apply, or using a lottery system. In either case this can result in a multi-year wait in order to begin training.
- Community Colleges have the option of contracting with employers or with WIBs and "selling" entire classes. In these circumstances the agency contracting for the class decides who does and doesn't get enrolled. This can be done with LVN or RN courses. It can also be done with other vocational education classes of interest to employers. Such programs can often be taught on site in SNFs by Community College instructors. Contracted training courses can offer the same academic credits that regular programs do, if the contracting agency so desires.
- The Community College System provides a series of regional resource centers specifically to assist schools and employers with issues dealing with health related training. Called the Regional Health Occupation Resource Centers (RHORC), these centers can assist with finding appropriate training programs, developing curriculum and coordinating efforts with multiple Community Colleges. RHORCs are also a potential source for additional funding from the Community College System's economic development funds.

Pell Grants and Student Loans—In some cases employees looking to advance their education may qualify for Pell Grants or for Student Loans. These are programs designed to benefit individuals and cannot be utilized by employers. However, if employees are already utilizing funds from these sources they can be used to help offset the cost employers will have to pay for training programs

- Pell Grants are federally funded education grants for low-income individuals. These are one-year grants (it is possible to apply in multiple years) that are paid directly to the school. Not all candidates are eligible, and not all candidate will qualify for multiple payments.
- Student Loans are federally guaranteed low-interest loans. Applicants must qualify based on their income. If approved, students receive the payment directly, and are responsible for repaying the money over an extended period.

Appendix 1
Statutory Language (From AB1629)

Link to the full text of AB1629:
www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/pdfs/Legislation.pdf

The following excerpts represent the current guidance that is available to employers for implementation of the Caregiver Training provisions of AB1629.

AB1629, as Chaptered September 29, 2004

SEC. 5. Article 3.8 (commencing with Section 14126) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code
Article 3.8. Medi-Cal Long-Term Care Reimbursement Act 14126. This article shall be known as the Medi-Cal Long-Term Care Reimbursement Act.

14126.021. The department shall develop and implement a cost-based reimbursement rate methodology using the cost categories as described in Section 14126.023, for freestanding nursing facilities 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.

14126.023. (a) The methodology developed pursuant to this article shall be facility specific and reflect the sum of the projected cost of each cost category and passthrough costs, as follows:

(1) Labor costs limited as specified in subdivision (c).

(2) Indirect care nonlabor costs limited to the 75th percentile.

(3) Administrative costs limited to the 50th percentile.

(4) Capital costs based on a fair rental value system (FRVS) limited as specified in subdivision (d).

(5) **Direct passthrough of proportional Medi-Cal costs for** property taxes, facility license fees, new state and federal mandates, **caregiver training costs**, and liability insurance projected on the prior year's costs.

Appendix 2
Intent Language From Governor's Signing Message

Link to the full text of the Governor's Signing Message:
www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/pdfs/Legislation.pdf

Governor's Signing Message for AB1629
Published September 29, 2004

Governor Schwarzenegger provided a signing message for AB1629 that clearly states his intent to use the additional funding as a tool to improve quality of care in nursing homes. The following excerpts from the Governor's Signing Message help to highlight the need for clear guidance to employers on how to access AB1629 Caregiver Training funds.

> "This bill will sunset on July 31, 2008, at which time we will examine available information regarding the impact of the new rate methodology on the State General Fund and improvements in quality of care and retention of staff, to decide whether changes should be made to the rate methodology or the quality assurance components of the bill."

> "The most important point of AB 1629, however, must not be forgotten. This rate increase is to improve the care of residents in nursing facilities. I am directing the Department of Health Services to closely monitor implementation and to identify opportunities to recognize and reward quality care. We are making this investment in nursing facilities to ensure better care, and I intend to hold the industry and caregivers accountable for this critical responsibility."

Appendix 3
Regulatory Language from the State Medicaid Plan Amendment

State Plan Amendment 04-012, Supplement 4 to Attachment 4.19-d
Transmitted to Center for Medicare and Medicaid Studies February 1, 2005
Approved by CMS on May 2, 2005

C. Cost Categories. The facility-specific cost-based per diem payment for FS/NF-Bs is based on the sum of the projected costs of the five major cost categories, each subject to ceilings described in this Section. Costs within a specific cost category may not be shifted to any other cost category. In addition, per diem costs will be subject to overall limitations described in Section VI of this Supplement.

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

b. 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 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.

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

September 5, 2006

Mr. Michael Bernick
Milken Institute
1250 Fourth Street
Santa Monica, CA 90401-1353

Dear Mr. Bernick:

Thank you for your letter to Licensing and Certification requesting clarification of training reimbursement under Assembly Bill 1629 (Chapter 875, Statutes of 2004). Your letter has been referred to Medical Care Services for reply.

The California Department of Health Services (CDHS) has for many years used the Accounting and Reporting Manual for California Long-Term Care Facilities, produced by the Office of Statewide Health Planning and Development (OSHPD), to define in-service education. The CDHS has clearly reiterated the OSHPD definition of "formal" and "informal" training in our policies and procedures relating to reimbursement. Recent clarification was provided in Medi-Cal LongTerm Care Bulletin (LTC) #352, July 2006, (copy enclosed) defining caregiver training costs as "a formal program of education that is organized to train students to enter a caregiver occupational specialty." Providers receive and have on-line access to the Medi-Cal Bulletins providing clarification to Medi-Cal policies and/or AB1629.

Assembly Bill 1629 states that "caregiver training" is a Direct Pass-Through Cost and "in-service education" is an Indirect Care Labor Cost. The State Plan Amendment #05-005, approved September 9, 2005, further defines caregiver training costs as "...a formal program of education that is organized to train students to enter a caregiver occupational specialty" and in-service education activities as "...education conducted within the freestanding nursing facility, level-B for facility nursing personnel."

With regards to the chart attached to your letter, the assignment of costs between caregiver training and labor costs are generally correct when the training is required for a facility to obtain and maintain licensure. However, CDHS is not aware that a Certified Memory Impairment Specialist is required for facility licensing.

1501 Capitol Avenue, Suite 71.6086, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
(916) 440-7800 Fax: (916) 440-7805
www.dhs.ca.gov

CDHS believes there is current and adequate clarification in Assembly Bill 1629, State Plan Amendment #05-005, Medi-Cal LTC Bulletins, and the myriad of correspondence for all providers to correctly interpret and assign training costs. If you have further concerns, please contact Ms. Cecilia Keiser at 916-552-9541.

Sincerely,

Stan Rosenstein
Deputy Director
Medical Care Services

Enclosure

cc: Mr. Timothy Matsumoto, Chief
Provider Rate Section
Rate Development Branch
California Department of Health Services
1501 Capital Avenue, MS 4600
Sacramento, CA 95899-7417

Appendix 5
Response from DHS Regarding Guidelines for Caregiver Training

Keiser, Cecilia (DHS-MCPD-RDB)

CKeiser@dhs.ca.gov
6/6/2006 1:38 PM

Darryl, a number of folks reviewed this series of questions. Our consensus is that the OSHPD manual and federal guidelines are the basis for our comments.

The program has to be a formal education program required for a state license and the program has to be nationally or state licensing accredited for the basic nursing provider category. The continuing education programs that do not lead to a required license or certification are part of the general program. For example, CPR training does not lead to a real license e.g. LVN or RN etc. Only an education program organized by the facility, or where the facility hires an outside vendor to conduct the training, should count as a "formal program of education."

Only direct costs attributable to the program count. Wages do not count as those are direct labor not under the care giver pass through. Paying the tuition for an employee to go to school is an employee benefit cost. Paying for an employee's time while going to school is also a benefit cost.

They also cannot count training for non provider categories, e.g., dietetic aide is not a licensing category, nor is supervisor of nursing. The occupational specialty should be one that is widely recognized and preferably one that has an independent certifying body. The education they receive should qualify them for the same position with other employers. The training should be one which prepares the person to enter an occupational specialty. For example, CPR certification on its own does not prepare someone to be a CNA.

We feel providers should rely on the OSHPD and federal guidelines to determine if their program meets those guidelines.

MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Long Term Care

July 2006 • Bulletin 352

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. <u>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.</u>

(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. **<u>For purposes of facility-specific reimbursement, indirect care labor cost grouping includes both permanent and temporary agency staff.</u>**

   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

.

Long Term Care Bulletin 352

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

hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification of its rate-of-increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(b) *Misclassification of GME costs*—(1) *General rule.* If costs that should have been classified as GME costs were treated as operating costs during both the GME base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as GME costs in the GME base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

[69 FR 49254, Aug. 11, 2004]

§ 413.85 Cost of approved nursing and allied health education activities.

(a) *Statutory basis.* This section implements section 1861(v)(1)(A) of the Act and section 4004(b) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) by establishing the methodology for Medicare payment of the costs of approved nursing and allied health education activities.

(b) *Scope.* (1) This section sets forth the rules for determining Medicare payments to hospitals for the costs of nursing and allied health education activities.

(2) This section does not address Medicare payments for the direct and indirect costs of graduate medical education (that is, approved residency programs in medicine, osteopathy, dentistry, and podiatry). Medicare payment for these costs is determined as provided in § 412.105 of this subchapter and§§ 413.75 through 413.83.

(3) The rules under this section do not apply to activities that are specified in paragraph (h) of this section and identified as normal operating costs.

(c) *Definitions.* For purposes of this section, the following definitions apply:

Approved educational activities means formally organized or planned programs of study of the type that:

(1) Are operated by providers as specified in paragraph (f) of this section;

(2) Enhance the quality of inpatient care at the provider; and

(3) Meet the requirements of paragraph (e) of this section for State licensure or accreditation.

Classroom instruction costs are those costs associated with formal, didactic instruction on a specific topic or subject in a class that meets at regular, scheduled intervals over a specific time period (for example, semester or quarter), and for which a student receives a grade.

Clinical training costs means costs of training for the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. Clinical training may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques; it involves no classroom instruction.

Community support means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.

Redistribution of costs means an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education or a medical school that were incurred by an educational institution and were not allowable to the provider in its prospective payment or rate-of-increase limit base year cost report, or graduate medical education per resident amount calculated under §§ 413.75 through 413.83, are not allowable costs in subsequent fiscal years.

(d) *General payment rules.* (1) Payment for a provider's net cost of nursing and allied health education activities is determined on a reasonable cost basis, subject to the following conditions and limitations:

(i) An approved educational activity—

(A) Is recognized by a national approving body or State licensing authority as specified in paragraph (e) of this section;

(B) Meets the criteria specified in paragraph (f) of this section for identification as an operator of an approved education program.

(C) Enhances the quality of inpatient care at the provider.

(ii) The cost for certain nonprovider-operated programs are reimbursable on a reasonable cost basis if the programs meet the criteria specified in paragraph (g)(2) of this section.

(iii) The costs of certain nonprovider-operated programs at wholly owned subsidiary educational institutions are reimbursable on a reasonable cost basis if the provisions of paragraph (g)(3) of this section are met.

(2) *Determination of net cost.* (i) Subject to the provisions of paragraph (d)(2)(iii) of this section, the net cost of approved educational activities is determined by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs that are directly related to approved educational activities.

(ii) A provider's total allowable educational costs are those costs incurred by the provider for trainee stipends, compensation of teachers, and other costs of the activities as determined under the Medicare cost-finding principles in § 413.24. These costs do not include patient care costs, costs incurred by a related organization, or costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support.

(iii) The net costs of approved certified registered nurse anesthetist (CRNA) education programs that are determined on a reasonable cost basis are subject to the additional condition that allowable compensation costs for faculty members who are CRNAs are limited to the compensation costs for administrative activities related to the educational program, the compensation costs directly related to hours spent in classroom instruction, and the costs related to the clinical training of students for which the CRNA may not receive payment under the CRNA fee

schedule. No pass-through compensation costs are allowable for the time a CRNA spends in the clinical training of a student anesthetist during a surgical procedure in the operating room for which the CRNA may receive payment under the CRNA fee schedule. As specified at § 414.46 of this chapter, if the CRNA continuously supervises the services of a single student nurse anesthetist, or where the medical direction rules allow a CRNA to bill for the service, payment can be made under the CRNA fee schedule.

(iv) Net costs are subject to apportionment for Medicare utilization as described in § 413.50.

(e) *Approved nursing and allied health education programs.* CMS will consider an activity an approved nursing and allied health education program if the program is a planned program of study that is licensed by State law, or if licensing is not required, is accredited by the recognized national professional organization for the particular activity. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs, the National League of Nursing Accrediting Commission, the Association for Clinical Pastoral Education Inc., and the American Dietetic Association.

(f) *Criteria for identifying programs operated by a provider.* (1) Except as provided in paragraph (f)(2) of this section, for cost reporting periods beginning on or after October 1, 1983, in order to be considered the operator of an approved nursing or allied health education program, a provider must meet all of the following requirements:

(i) Directly incur the training costs.

(ii) Have direct control of the program curriculum. (A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)

(iii) Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.)

(iv) Employ the teaching staff.

(v) Provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.

(2) Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program.

(g) *Payment for certain nonprovider-operated programs.* (1) *Payment rule.* Costs incurred by a provider, or by an educational institution that is related to the provider by common ownership or control (that is, a related organization as defined in § 413.17(b)), for the clinical training of students enrolled in an approved nursing or allied health education program that is not operated by the provider, are paid on a reasonable cost basis if the conditions specified in paragraph (g)(2) of this section are met.

(2) *Criteria for identification of nonprovider-operated education programs.* Payment for the incurred costs of educational activities identified in paragraph (g)(1) of this section will be made if the following conditions are met:

(i) The clinical training must occur on the premises of the provider, that is, in the hospital itself or in the physical area immediately adjacent to the provider's main buildings, or in other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings.

(ii) The provider must have claimed and been paid for clinical training costs on a reasonable cost basis during the most recent cost reporting period that ended on or before October 1, 1989. This condition is met if a notice of program reimbursement (NPR) was issued

for that cost reporting period by November 5, 1990, and the clinical training costs were included as pass-through costs. If an NPR was not issued by that date, or an NPR was issued but did not treat the clinical training costs as pass-through costs, the condition is met if—

(A) The intermediary included the clinical training costs in the allowable costs used to determine the interim rate for the most recent cost reporting period ending on or before October 1, 1989; or

(B) The provider claimed the clinical training costs as pass-through costs when the cost report for the most recent cost reporting period ending on or before October 1, 1989, was initially submitted.

(iii) In any cost reporting period, the percentage of total allowable provider cost attributable to allowable clinical training cost does not exceed the percentage of total cost for clinical training in the provider's most recent cost reporting period ending on or before October 1, 1989.

(iv) The students in the educational program must provide a benefit to the provider through the provision of clinical services to patients of the provider.

(v) The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common control or ownership as defined in § 413.17(b) (''*Cost to related organizations.*'') Costs incurred by a third-party, regardless of its relationship to either the provider or the educational institution, are not allowed.

(vi) The costs incurred by a provider does not exceed the costs the provider would have incurred if it was the sole operator of the program.

(3) *Special rule: Payment for certain nonprovider-operated programs at wholly owned subsidiary educational institutions.* (i) Effective for portions of cost reporting periods occurring on or after October 1, 2003, a provider that incurs costs for a nursing or allied health education program(s) where those program(s) had originally been provider-operated according to the criteria at paragraph (f) of this section, and then operation of the program(s) was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the provider has continuously incurred the costs of both the classroom and clinical training portions of the program(s) at the educational institution, may receive reasonable cost payment for such a program(s) according to the specifications under paragraphs (g)(3)(ii) and (g)(3)(iii) of this section.

(ii) Payment for the incurred costs of educational activities identified in paragraph (g)(3)(i) of this section will be made on a reasonable cost basis if a provider, as described in paragraph (g)(3)(i) of this section, received Medicare reasonable cost payment for those nursing and allied health education program(s) both prior and subsequent to the date the provider transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program(s) according to the criteria under paragraph (f) of this section).

(iii) The provider that meets the requirements in paragraphs (g)(3)(i) and (g)(3)(ii) of this section will be eligible to receive payment under this paragraph for: (A) the clinical training costs incurred for the program(s) as described in paragraph (g)(3)(i) of this section; and (B) classroom costs, but only those costs incurred by the provider for the courses that were included in the programs.

(h) *Cost of educational activities treated as normal operating costs.* The costs of the following educational activities incurred by a provider but not operated by that provider are recognized only as normal operating costs and paid in accordance with the reimbursement principles specified in Part 412 of this subchapter. They include:

(1) Orientation and on-the-job training.

(2) Part-time education for bona fide full-time employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work.

(3) Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider

and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

(4) Maintenance of a medical library.

(5) Training of a patient or patient's family in the use of medical appliances or other treatments.

(6) Except as provided in paragraph (g) of this section, clinical training and classroom instruction of students enrolled in an educational program that is not operated by the provider. The following are clinical training and classroom instruction costs that are allowable as normal operating costs:

(i) Costs incurred in the clinical training of students, including the clinical training or clerkship of undergraduate medical school students that takes place in a provider.

(ii) Classroom instruction costs incurred by a provider that meet the following criteria:

(A) The provider's support does not constitute a redistribution of nonprovider costs to the provider. The support must be in addition to the costs already being incurred by the nonprovider-operated program. If the nonprovider entity reduces its costs due to receiving provider support, this reduction constitutes a redistribution of costs from an educational institution to a patient care institution and is a nonallowable provider cost.

(B) The provider receives a benefit for the support it furnishes.

(C) The cost of the provider's support is less than the cost the provider would incur were it to operate the program.

(7) Other activities that do not involve the actual operation of an approved educational program.

[66 FR 3374, Jan. 12, 2001, as amended at 66 FR 14342, Mar. 12, 2001; 68 FR 45471, Aug. 1, 2003; 69 FR 49254, Aug. 11, 2004]

§ 413.87 Payments for Medicare+Choice nursing and allied health education programs.

(a) *Statutory basis.* This section implements section 1886(l) of the Act, which provides for additional payments to hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.

(b) *Scope.* This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under § 413.85.

(c) *Qualifying conditions for payment.*

(1) For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, a hospital that operates and receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount associated with Medicare+Choice utilization. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section are met.

(i) The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (For example, if the current year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998.) For a hospital that first establishes a nursing or allied health education program after FY 1998 and receives reasonable cost payment for the program as specified under § 413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is 2 years after the respective fiscal year so long as the hospital also meets the condition under paragraph (c)(1(ii) of this section.

(ii) The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under § 413.85 in the current calendar year.

(2) For portions of cost reporting periods occurring on or after January 1, 2001, in addition to meeting the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, the hospital must have had a Medicare+Choice utilization greater than zero in its cost reporting period(s) ending in the fiscal

Appendix 8
Local Workforce Investment Boards

Alameda County Consortium (ACTEB) Workforce Investment Board
Serving: Alameda County, excluding the City of Oakland
Appointed by: President, Alameda County Board of Supervisors

Dorothy Chen, Director
Alameda County Workforce Investment Board
24100 Amador Street
Hayward, CA 94544
Phone: (510) 259-3841
Fax: (510) 259-3845
E-Mail: dchen@co.alameda,ca.us
Web Site: www.acwib.org

Carson, Lomita, Torrance Consortium Workforce Investment Board
Serving: Cities of Carson, Lomita, & Torrance, and the LA Harbor area
Appointed by: Mayor of Torrance

Patricia D. Unangst, Administrator
Carson, Lomita, Torrance Consortium
One Civic Plaza, Suite 500
Carson, CA 90745
Phone: (310) 518-8130
Fax: (310) 518-8214
E-Mail: punangst@torrnet.com
Web Site: www.careerzone.torrnet.com

City of Anaheim Workforce Investment Board
Serving: City of Anaheim
Appointed by: Mayor of Anaheim

Ruben Aceves, Job Training Program Manager
City of Anaheim
50 South Anaheim Blvd., Suite 200
Anaheim, CA 92805
Phone: (714) 765-4342
Fax: (714) 765-4363
E-Mail: raceves@anaheim.net
Web Site: www.anaheim.net

Greater Long Beach Workforce Development Board
Serving: Cities of Long Beach and Signal Hill
Appointed by: Mayor of Long Beach

Bryan Rogers, Administrator
Greater Long Beach Workforce Development Board
200 Pine Ave., Suite 400
Long Beach, CA 90802
Phone: (562) 570-7730
Fax: (562) 570-7733
E-Mail: raworde@ci.long-beach.ca.us
Web Site: www.longbeachworkforce.org

City of Los Angeles Workforce Investment Board
Serving: City of Los Angeles
Appointed by: Mayor of Los Angeles

??, Executive Director
City of Los Angeles Workforce Investment Board
350 South Bixel Street, Suite 160
Los Angeles, CA 90017
Phone: (213) 482-2915
Fax: (213) 482-2921
Web Site: www.lacity.org/wib

City of Oakland Workforce Investment Board
Serving: City of Oakland
Appointed by: Mayor of Oakland

Al Auletta, Executive Director
City of Oakland Community and Economic Development Agency
250 Frank Ogawa Plaza, Suite 3315
Oakland, CA 94612
Phone: (510) 238-3752
Fax: (510) 238-2230
Web Site: www.oaklandwib.org/main

City of Richmond Workforce Investment Board
Serving: City of Richmond
Appointed by: Mayor of Richmond

Sal Vaca, Director
Richmond City Employment & Training Program
330 25th Street
Richmond, CA 94804
Phone: (510) 307-8153
Fax: (510) 307-8072
E-Mail: umtambuzi@richmondworks.org
Web Site: www.richmondworks.org/index.htm

City of San Bernardino Workforce Investment Board
Serving: City of San Bernardino
Appointed by: Mayor of San Bernardino

Ernest Dowdy, Executive Director
City of San Bernardino Employment and Training Agency
599 North Arrowhead Avenue
San Bernardino, CA 92401
Phone: (909) 888-7881
Fax: (909) 889-7833
E-Mail: ebdowdy@sbeta.com
Web Site: www.sbeta.com

Appendix 8
Local Workforce Investment Boards

City of Santa Ana Workforce Investment Board

Serving: City of Santa Ana

Appointed by: Mayor of Santa Ana

Linda Summers, Executive Director
Santa Ana Workforce Investment Board
1000 East Santa Ana Blvd.
Santa Ana, CA 92701
Phone: (714) 565-2600
Fax: (714) 565-2602
E-Mail: pnunn@ci.santa-ana.ca.us
Web Site: www.santaanawib.com

Contra Costa County Workforce Investment Board

Serving: Contra Costa County, excluding the City of Richmond

Appointed by: Chair, Contra Costa County Board of Supervisors

Robert Lanter, Executive Director
Contra Costa County Workforce Investment Board
2425 Bisso Lane, Suite 100
Concord, CA 94520-4817
Phone: (925) 646-5239
Fax: (925) 646-5517
Web Site: www.wdbccc.com

Foothill Consortium Workforce Investment Board

Serving: Cities of Arcadia, Duarte, Monrovia, Pasadena, Sierra Madre, and South Pasadena

Appointed by: Chair, Foothill Policy Board

Phillip Dunn, Executive Director
Foothill Employment & Training Consortium
1207 East Green Street
Pasadena, CA 91106
Phone: (626) 584-8381
Fax: (626) 584-8375
E-Mail: npdunn@ci.pasadena.ca.us.
Web Site: www.foothilletc.org

Fresno City/County Consortium Workforce Investment Board

Serving: Fresno County

Appointed by: Chair, Fresno County Board of Supervisors

Blake Konczal, Chief Executive Officer
Fresno Area Workforce Investment Corporation
2035 Tulare Street, Suite 203
Fresno, CA 93721
Phone: (559) 490-7102
Fax: (559) 233-9633
E-Mail: cmerzon@jobsfresno.com
Web Site: www.jobsfresno.com

Golden Sierra Consortium Workforce Investment Board

Serving: Alpine, El Dorado, Nevada, Placer, and Sierra Counties

Appointed by: Chair, Alpine County Board of Supervisors

George Hempe, Executive Director
Golden Sierra Job Training Agency
11549 F Avenue
Auburn, CA 95603
Phone: (530) 823-4635
Fax: (530) 885-5579
E-Mail: khemmer@psyber.com
Web Site: www.goldensierra.com

Humboldt County Workforce Investment Board

Serving: Humboldt County

Appointed by: Chair, Humboldt County Board of Supervisors

Jaqueline Debets, Executive Director
Humboldt County Community Development Services,
Economic Development Division
520 E Street
Eureka, CA 95501
Phone: (707) 445-7745
Fax: (707) 445-7219
Web Site: www.humboldtwib.com

Imperial County Workforce Investment Board

Serving: Imperial County

Appointed by: Chair, Imperial County Board of Supervisors

Ken Phillips, Executive Director
Workforce Investment Board of Imperial County
P.O. Box 618
El Centro, CA 92243
Phone: (760) 353-5050
Fax: (760) 353-6594

Kern/Inyo/Mono Consortium Workforce Investment Board

Serving: Kern, Inyo and Mono Counties

Appointed by: Chair, Kern County Board of Supervisors

Verna Lewis, Executive Director
Employers' Training Resource
2001 - 28th Street
Bakersfield, CA 93301
Phone: (661) 336-6849
Fax: (661) 336-6855
E-Mail: nilon@kerncounty.com
Web Site: www.etronline.com

Appendix 8
Local Workforce Investment Boards

Kings County Workforce Investment Board

Serving: Kings County

Appointed by: Chair, Kings County Board of Supervisors

John Lehn, Director
Kings County Government Center
124 North Irwin Street
Hanford, CA 93230
Phone: (559) 585-3532
Fax: (559) 585-7395
E-Mail: jlehn@co.kings.ca.us
Web Site: www.kingsworkforce.org

Los Angeles County Workforce Investment Board

Serving: The unincorporated areas of Los Angeles County, excluding the City of Signal Hill

Appointed by: Chair, Los Angeles County Board of Supervisors

Josie Marquez, Director
Department of Community and Senior Services, Employment and Training Branch
3175 West Sixth Street, Room 406
Los Angeles, CA 90020
Phone: (213) 738-3175
Fax: (213) 385-3468
Web Site: wib.co.la.ca.us/

Madera County Workforce Investment Board

Serving: Madera County

Appointed by: Chair, Madera County Board of Supervisors

Elaine M. Craig, Division Administrator
Madera County Workforce Development Office
209 East 7th Street
Madera, CA 93638
Phone: (559) 662-4600
Fax: (559) 673-1794
E-Mail: hperez@maderacoe.k12.ca.us
Web Site: www.maderaworkforce.org

Marin County Workforce Investment Board

Serving: Marin County

Appointed by: President, Marin County Board of Supervisors

Richard Schorske, Director
Workforce Investment Board of Marin County
120 N. Redwood Drive - East
San Rafael, CA 94903
Phone: (415) 883-2502
Fax: (415) 883-2503
Web Site: www.marinemployment.org

Mendocino County Workforce Investment Board

Serving: Mendocino County

Appointed by: Chair, Mendocino County Board of Supervisors

Colleen Henderson, WIA Coordinator
Mendocino County Workforce Investment Board
631 South Orchard Street
Ukiah, CA 95482
Phone: (707) 463-6390
Fax: (707) 463-6392
Web Site: www.mendowib.org

Merced County Workforce Investment Board

Serving: Merced County

Appointed by: Chair, Merced County Board of Supervisors

Andrea Baker, Director
Merced County Department of Workforce Investment
1880 West Wardrobe Avenue
Merced, CA 95340-6407
Phone: (209) 385-7324, ext. 2003
Fax: (209) 725-3592
E-Mail: PITD1@co.merced.ca.us
Web Site: www.co.merced.ca.us/pitd

Monterey County Workforce Investment Board

Serving: Monterey County

Appointed by: Chair, Monterey County Board of Supervisors

Joseph Werner, Executive Director
Monterey County Employment Training Office
730 LaGuardia Street
Salinas, CA 93905-3354
Phone: (831) 759-6644
Fax: (831) 755-0938
E-Mail: wernerj@co.monterey.ca.us
Web Site: www.co.monterey.ca.us/onestop/oet.htm

Mother Lode Consortium Workforce Investment Board

Serving: Amador, Calaveras, Tuolumne, and Mariposa

Appointed by: Chair of your Board of Directors

Robert Martin, Director
Mother Lode Consortium
19900 Cedar Road - North
Sonora, CA 95370
Phone: (209) 533-3396
Fax: (209) 533-1079
E-Mail: admin@mljt.org
Web Site: www.jobconnect.org

Appendix 8
Local Workforce Investment Boards

Napa County Workforce Investment Board

Serving: Napa County

Appointed by: Chair, Napa County Board of Supervisors

Bruce Wilson, Director
Workforce Investment Board of Napa County
650 Imperial Way, Suite 101
Napa, CA 94559-1344
Phone: (707) 259-8362
Fax: (707) 253-4893
E-Mail: mfinnegan@co.napa.ca.us

North Central Counties Consortium (NCCC) Workforce Investment Board

Serving: Colusa, Glenn, Lake, Yuba, and Sutter counties

Appointed by: Chair, NCCC governing board

Stewart Knox, Executive Director
North Central Counties Consortium
1215 Plumas Street, Suite 1800
Yuba City, CA 95991
Phone: (530) 822-7145
Fax: (530) 822-7150
E-Mail: cpeterson@ncen.org
Web Site: www.northcounties.org

North Valley Job Training Consortium (NOVA) Workforce Investment Board

Serving: Cities of Cupertino, Los Altos, Milpitas, Mountain View, Palo Alto, Santa Clara & Sunnyvale

Appointed by: Mayor of Sunnyvale

Michael Curran, Director
NOVA Consortium (North Santa Clara)
505 W. Olive Avenue, Suite 550
Sunnyvale, CA 94086
Phone: (408) 730-7248
Fax: (408) 730-7643
E-Mail: mcurran@novapic.org
Web Site: www.novapic.org

Northern Rural Training and Employment Consortium (NoRTEC) Workforce Investment Board

Serving: Butte, Del Norte, Lassen, Modoc, Plumas, Siskiyou, Tehama, and Trinity counties

Appointed by: Chair of the NoRTEC Board

Charles Brown, Executive Director
NoRTEC Governing Board
7420 Skyway
Paradise, CA 95969
Phone: (530) 872-9600
Fax: (530) 872-5647
E-Mail: cbrown@ncen.org
Web Site: www.nortec.org/cb/nortec.html

Orange County Workforce Investment Board

Serving: Orange County, excluding the Cities of Anaheim and Santa Ana.

Appointed by: Chair, Orange County Board of Supervisors

Andrew Munoz, WIA Administrator
Orange County Community Services Agency
1300 South Grand, Bldg. B, 3rd Floor
Santa Ana, CA 92705-4407
Phone: (714) 567-7371
Fax: (714) 834-7132
E-Mail: andrewm@jtpa.csa.co.orange.ca.us
Web Site: www.ocwib.org

Riverside County Workforce Investment Board

Serving: Riverside County

Appointed by: Chair, Riverside County Board of Supervisors

Kathy Fortner, Deputy Director
Riverside County Economic Development Agency
1151 Spruce Street
Riverside, CA 92507
Phone: (909) 955-3100
Fax: (909) 955-3131
E-Mail: eda2.jcraig@co.riverside.ca.us
Web Site: www.rivcojobs.com

Sacramento City/County Consortium Workforce Investment Board

Serving: County and City of Sacramento

Appointed by: Sacramento Employment and Training Agency Governing Board

Kathy Kossick, Executive Director
Sacramento Employment & Training Agency
1217 Del Paso Blvd.
Sacramento, CA 95815
Phone: (916) 263-3800
Fax: (916) 863-3825
E-Mail: kathy@delpaso.seta.net
Web Site: www.seta.net

San Benito County Workforce Investment Board

Serving: San Benito County

Appointed by: Chair, San Benito County Board of Supervisors

Maria Fehl, Director
San Benito County Community Services & Workforce Development
1131 San Felipe Road
Hollister, CA 95023
Phone: (831) 637-9293
Fax: (831) 637-0996
E-Mail: kflores@holinet.com
Web Site: www.sbcjobs.org

Appendix 8
Local Workforce Investment Boards

San Bernardino County Workforce Investment Board

Serving: San Bernardino County, excluding the City of San Bernardino

Appointed by: Second District County Board of Supervisors

Barbara Halsey, Director
San Bernardino County Jobs & Employment Services Dept.
851 S. Mount Vernon Ave., Suite 22
Colton, CA 92324
Phone: (909) 433-3330
Fax: (909) 433-3333
E-Mail: ssoto@jesd.co.san-bernardino.ca.us
Web Site: www.jesd.com/jobseekers.asp

San Diego County/City Workforce Investment Board

Serving: San Diego County

Appointed by: Consortium Policy Board Chair

Lawrence Fitch, Executive Director
San Diego Workforce Partnership, Inc.
1551 Fourth Avenue, Suite 600
San Diego, CA 92101
Phone: (619) 238-1445
Fax: (619) 238-5159
E-Mail: lgfitch@workforce.org
Web Site: www.workforce.org

San Francisco City and County Workforce Investment Board

Serving: City/County of San Francisco

Appointed by: Mayor of San Francisco

Rhonda Simmons, President
Private Industry Council of San Francisco, Inc.
1650 Mission Street, Suite 300
San Francisco, CA 94103-2490
Phone: (415) 431-8700
Fax: (415) 431-8702
E-Mail: 411@picsf.org
Web Site: www.picsf.org

San Joaquin County Workforce Investment Board

Serving: San Joaquin County

Appointed by: Chair, San Joaquin County Board of Supervisors

John Solis, Executive Director
San Joaquin County Employment & Economic Development Department
850 N. Hunter Street
Stockton, CA 95202
Phone: (209) 468-3526
Fax: (209) 462-9063
E-Mail: jsolis@co.san-joaquin.ca.us
Web Site: www.sjcworknet.org

Silicon Workforce Investment Board

Serving: City of San Jose
Appointed by: Mayor of San Jose
Jeff Ruster, Director
Silicon Valley Workforce Investment Network
60 South Market Street, Suite 470
San Jose, CA 95113
Phone: (408) 928-1301
Fax: (408) 251-0364
Web Site: www.siliconvalleywin.org

San Luis Obispo County Workforce Investment Board

Serving: San Luis Obispo County

Appointed by: Chair, San Luis Obispo County Board of Supervisors

Lee Ferrero, President
Private Industry Council of San Luis Obispo County
4111 Broad Street, Suite A
San Luis Obispo, CA 93401
Phone: (805) 788-2600
Fax: (805) 541-4117
E-Mail: lferrero@jobhunt.org
Web Site: www.jobhunt.org

San Mateo County Workforce Investment Board

Serving: San Mateo County

Appointed by: President, San Mateo County Board of Supervisors

Fred Slone, Director
County of San Mateo Workforce Investment Board
400 Harbor Blvd., Bldg. B
Belmont, CA 94002
Phone: (650) 802-5181
Fax: (650) 802-5173

Santa Barbara County Workforce Investment Board

Serving: Santa Barbara County

Appointed by: Chair, Santa Barbara County Board of Supervisors

Michael Gregory, Executive Director
Workforce Investment Board, c/o Dept. of Social Services
234 Camino del Remedio
Santa Barbara, CA 93110
Phone: (805) 681-4446
Fax: (805) 681-4403
Web Site: www.workforceresource.com

Appendix 8
Local Workforce Investment Boards

Santa Cruz County Workforce Investment Board
Serving: Santa Cruz County
Appointed by: Chair, Santa Cruz County Board of Supervisors

Kathy Zwart, Assistant Director
Santa Cruz County Human Resource Agency
1040 Emeline Avenue
Santa Cruz, CA 95060
Phone: (831) 454-4080
Fax: (831) 454-4651
Web Site: www.workforcescc.com

Solano County Workforce Investment Board

Serving: Solano County

Appointed by: Chair, Solano County Board of Supervisors

Robert Bloom, Executive Director
Workforce Investment Board of Solano County
320 Campus Lane
Suisun, Ca 94585
Phone: (707) 864-3370
Fax: (707) 864-3386
E-Mail: rbloom@solanopic.org
Web Site: www.solanowib.org

Sonoma County Workforce Investment Board

Serving: Sonoma County

Appointed by: Chair, Sonoma Board of Supervisors

Jerry Dunn, Director
Sonoma County Workforce Investment Board
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407
Phone: (707) 565-8501
Fax: (707) 565-8515
E-Mail: jdunn@sonoma-county.org
Web Site: www.socojoblink.org

South Bay Consortium Workforce Investment Board

Serving: Cities of El Segundo, Gardena, Hawthorne, Hermosa Beach, Inglewood, Lawndale, Manhattan Beach, Redondo Beach

Appointed by: Mayor of Inglewood

Jan Vogel, Administrator
South Bay Workforce Investment Board
11539 Hawthorne Blvd., Suite 500
Hawthorne, CA 90250
Phone: (310) 970-7700
Fax: (310) 970-7711
Web Site: www.sbwib.org

South East Los Angeles County (SELACO) Consortium Workforce Investment Board

Serving: Cities of Artesia, Bellflower, Cerritos, Downey, Hawaiian Gardens, Lakewood,Norwalk

Appointed by: Chair of the SELACO Policy Board

Ron Crossley, Executive Director
Southeast Los Angeles County Workforce Investment Board
10900 E. 183rd Street, Suite 350
Cerritos, CA 90703
Phone: (562) 402-9336
Fax: (562) 860-4701
Web Site: www.selaco.com

Stanislaus County Workforce Investment Board
Serving: Stanislaus County
Appointed by: Chair, Stanislaus County Board of Supervisors

Jeff Rowe, Director
Stanislaus County Department of Employment & Training
251 Hackett Road, C-2
Modesto, CA 95358-0031
Phone: (209) 558-2100
Fax: (209) 558-2164
Web Site: www.stannet.org

Tulare County Workforce Investment Board
Serving: Tulare County
Appointed by: Chair, Tulare County Board of Supervisors

Joseph Daniel, Administrator
Tulare County Workforce Investment Board
4025 West Noble Avenue
Visalia, CA 93277
Phone: (559) 713-5200
Fax: (559) 713-5263
E-Mail: main.jdaniel@tcwib.org
Web Site: www.tcwib.org

Ventura County Workforce Investment Board
Serving: Ventura County
Appointed by: Chair, Ventura County Board of Supervisors

Elaine Crandall, Director
Workforce Development Division
505 Poli Street
Ventura, CA 93001
Phone: (805) 652-7684
Fax: (805) 648-9533
E-Mail: bruce.stenslie@mail.co.ventura.ca.us
Web Site: www.wib.ventura.org

Appendix 8
Local Workforce Investment Boards

Verdugo Consortium Workforce Investment Board

Serving: Cities of Glendale, Burbank, and LaCanada-Flintridge

Appointed by: Mayor of Glendale

Bob Driffill, Director
Verdugo Private Industry Council
141 North Glendale Ave., Room 202
Glendale, CA 91206-4996
Phone: (818) 548-2053
Fax: (818) 548-3724
E-Mail: mblake@glendale.ci.ca.us
Web Site: www.verdugojobscenter.org

Yolo County Workforce Investment Board

Serving: Yolo County

Appointed by: Chair, Yolo County Board of Supervisors

Teri Ruggiero, Director
Yolo County Department of Employment and Social Services
25 North Cottonwood Street
Woodland, CA 95695
Phone: (530) 661-2750
Fax: (530) 661-2658
Web Site: www.yoloworks.org

Appendix 9
Community College Regional Health Occupation Resource Centers

California Health Care Initiative (HCI)
Jim Comins, RN, MS
Health Care Initiative Director
Sacramento City College (Lead College)
3835 Freeport Blvd., Instruction Office
Sacramento, CA 95822
Phone: (916) 558-2569
Website: www.healthoccupations.org

North /FarNorth RHORC
Linda Zorn, MA, RD, FAWHP Director
Butte College
2050 Talbert Drive, Suite 300
Chico, CA 95
Phone: (530)879-9069
Website: www.healthoccupations.org/rhorc/1

Interior Bay RHORC
Patty Perkins, MPH,MS Director
City College of San Francisco
1600 Holloway Ave. HSS 301
San Francisco, CA 94132-4161
Phone: (415) 405-0777
Website: www.healthoccupations.org/rhorc/4

Bay Area RHORC
Matthew Grayson Director
Mission College
3000 Mission College Blvd., MS #1
Santa Clara, CA 95054-1897
Phone: (408) 855-5215
Website: www.healthoccupations.org/rhorc/3

Central RHORC
Kathleen Schrader, DNSc, RN Director
Hartnell College
156 Homestead Avenue
Salinas, CA 93901
Phone: (831) 755-6916
Website: www.healthoccupations.org/rhorc/5

South Coast RHORC
Marsha Roberson, RN, MN Director
Santa Barbara City College
721 Cliff Drive, Santa Barbara, CA 93109-2394
Phone: (805) 956-0581 ext. 2782
Website: www:healthoccupations.org/rhorc/6

Los Angeles County RHORC
Jesus Oliva, MD Director
Mt. San Antonio Community College
1100 North Grand Avenue, Bldg. 35
Walnut, CA 91789
Phone: (909) 594-5611 ext.6101
Website: www.healthoccupations.org/rhorc/7
or www.rhorc.mtsac.edu

Orange/Inland Empire RHORC
Mary O'Connor, RN, MSN Director
Golden West College
15744 Golden West Street
P.O. Box 2748
Huntington Beach, CA 92647-2748
Phone: 714- 895-8975 FAX 714-895-8976
Website: www.healthoccupations.org/rhorc/8

San Diego/Imperial RHORC
Bob Yarris, PT, MA, MBA Director
Grossmont College
8800 Grossmont College Drive, Bldg. 343-C
El Cajon, CA 92020
Phone: (619) 644-7057 or 644-7059
Website: www.healthoccupations.org/rhorc/10

Appendix 10
California HealthCare Foundation/Milken Institute Contacts

California HealthCare Foundation
476 Ninth Street
Oakland, CA 94607
Phone: (510) 238-1040
Fax: (510) 238-1388
www.chcf.org

The Milken Institute
1250 Fourth Street
Santa Monica, CA 90401
Phone: (310) 570-4600
Fax: (310) 570-4601
www.milkeninstitute.org

Michael Bernick
Sedgwick, Detert, Moran & Arnold
One Market Plaza, Stewart Tower, 8th Floor
San Francisco, CA 94105
Phone: (415) 627-1446
E-Mail: michael.bernick@sdma.com

Kenneth Merchant
Ken Merchant Consulting Services
7112 Ansley Court
Citrus Heights, CA 95621
Phone: (916) 201-7351
E-Mail: kmerchant@rcsis.com