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

JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

September 30, 2015

Ms. Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services, Region IX
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 15-025

Dear Ms. Sam-Louie:

The California Department of Health Care Services (DHCS) is submitting the enclosed State Plan Amendment (SPA) 15-025 for your review and approval. SPA 15-025 is a technical update to remove all references to the Transitional Inpatient Care (TIC) Program from California's State Plan. The effective date for the SPA is July 1, 2015.

The state statute that authorized this program sunset in January 2003 and state regulations were repealed in 2006. TIC was developed by legislation to provide a level of care that allowed for reimbursement to hospitals when patients were less than acute but still needed some nursing level care. Terminating TIC did not impact Medi-Cal beneficiary's services because the program was based only on hospital reimbursement rates after services were provided.

DHCS has removed references to the TIC program from the pages listed below. Supplement 4 to Attachment 4.19-D – referenced on page 1 of Attachment 4.19-D – will be amended by SPA 15-032 when it is submitted this quarter. The following SPA documents are enclosed for your review and approval:

- HCFA Form 179 – Transmittal and Notice of Approval of State Plan Material
- Limitations on Attachment 3-1-A, pages 1.1 – 1.4, 8.6 (Redline Version)
- Limitations on Attachment 3-1-A, pages 1.1 – 1.4, 8.6 (Clean Version)
- Limitations on Attachment 3-1-B, pages 1.1 – 1.4, 8.6 (Redline Version)
- Limitations on Attachment 3-1-B, pages 1.1 – 1.4, 8.6 (Clean Version)
- Attachment 4.19-D, Pages 1, 2, 3, 4, 5, 9, 10, Table 1 (Redline Version)
- Attachment 4.19-D, Pages 1, 2, 3, 4, 5, 9, 10, Table 1 (Clean Version)

- Attachment 4.19-D, Supplement 3, pages 1-3 (Redline Version)
- Attachment 4.19-D, Supplement 3, pages 1-3 (Clean Version)
- Attachment 4.19-D, Appendix 4, pages 1-3 (Redline Version)
- Attachment 4.19-D, Appendix 4, pages 1-3 (Clean Version)

The Centers for Medicare and Medicaid Services notified DHCS on August 19, 2015 that we did not need to publish a tribal notice since the SPA will not impact Indian Health Programs or its beneficiaries.

If you have questions regarding the information provided, please contact Ms. Laurie Weaver, Assistant Deputy Director, Health Care Benefits and Eligibility, Acting Chief, Benefits Division, by phone at (916) 552-9619 or by email at Laurie.Weaver@dhcs.ca.gov.

ORIGINAL SIGNED

Mari Cantwell
Chief Deputy Director
Health Care Programs

cc: Donald A. Novo
Division of Medicaid and Children's Health Operations
San Francisco Regional Office
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-025**

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
n/a

7. FEDERAL BUDGET IMPACT:

a. FFY	2015	$	0
b. FFY	2016	$	0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Limitations on Attachment 3-1-A, Pages 1.1 – 1.4, 8.6
Limitations on Attachment 3-1-B, Pages 1.1 – 1.4, 8.6
Attachment 4.19-D, Pages 1, 2, 3, 4, 5, 9, 10, Table 1
Attachment 4.19-D, Supplement 3, Pages 1-3
Attachment 4.19-D, Appendix 4, Pages 1-3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Limitations on Attachment 3-1-A, Pages 1.1 – 1.4, 8.6
Limitations on Attachment 3-1-B, Pages 1.1 – 1.4, 8.6
Attachment 4.19-D, Pages 1, 2, 3, 4, 5, 9, 10, Table 1
Attachment 4.19-D, Supplement 3, Pages 1-3
Attachment 4.19-D, Appendix 4, Pages 1-3

10. SUBJECT OF AMENDMENT:
Remove references of the Transitional Inpatient Care Program

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

ORIGINAL SIGNED

13. TYPED NAME:
Mari Cantwell

14. TITLE:
Deputy Director
Health Care Programs
State Medicaid Director

SEP 30 2015

15. DATE SUBMITTED:

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, MS 4506
P.O. Box 997413
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

(f) DP/NP level B/pediatric subacute ... no bedsize category
(g) NF level A ... no bedsize category
(h) DP/NF level A ... no bedsize category
(i) ICF/DD ... 1-59, 60+ and 60+ with a distinct part
(j) ICF/DD-H ... 4-6 and 7-15
(k) ICF/DD-N ... 4-6 and 7-15
(l) Swing-beds ... no bedsize category

4. Geographical location:

(a) Freestanding NF levels A and B and DP/NF level A:
(1) Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, and Sonoma counties.
(2) Los Angeles county.
(3) All other counties.
(b) DP/NF level B, freestanding NF level B/subacute and pediatric subacute, DP/NF level B/subacute and pediatric subacute, ICF/DDs, ICF/DD-Hs, and ICF/DD-Ns, ... statewide.
(c) Rural swing-beds ... statewide.

J. Special Treatment Program (STP)

For eligible Medi-Cal patients 65 years or older who receive services in an Institution for Mental Disease the STP patch rate will apply. This is flat add-on rate determined to be the additional cost for facilities to perform these services. STP does not constitute a separate level of care.

II. COST REPORTING

A. All long term-care facilities participating in the Medi-Cal Program shall maintain, according to generally accepted accounting principles, the uniform accounting system's adopted by the State and shall submit cost reports in the manner approved by the State.

1. Cost Reports are due to the State no later than 120 days after the close of each facility's fiscal year (150 days for facilities that are distinct parts of a hospital), in accordance with Medicare and Medi-Cal cost reporting

STATE PLAN UNDER TITLE XIX OF SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT FOR ALL CATEGORIES OF NURSING FACILITIES AND

INTERMEDIATE CARE FACILITIES FOR THE DEVELOPMENTALLY DISABLED

The purpose of this State Plan is to (1) establish the principles of the State of California's reimbursement system for providers of long-term care services to assure compliance with the requirements of Title XIX of the Federal Social Security Act and the Code of Federal Regulations, and (2) describe the procedures to be followed by the single State agency, the Department of Health Services (herein called the Department), in determining long-term care reimbursement rates.

Beginning with the 2005/06 rate year, the reimbursement rate methodology applicable to long-term care freestanding nursing facilities level-B and subacute facilities is described in Supplement 4 to Attachment 4.19-D. Assembly Bill (AB) 1629 (Statutes 2004, Chapter 875) mandates a facility-specific reimbursement methodology to be effective on August 1, 2005. Subsequent legislation extended the current rate methodology established by AB 1629. Pursuant to AB 119 (Statutes 2015, Chapter 17), the rate methodology was extended to July 31, 2020. Therefore, the rate methodology in effect as of July 31, 2005, continues to be described in Attachment 4.19-D, Pages 1 through 22 of this State Plan.

I. GENERAL PROVISIONS

A. The State shall set prospective rates for services by various classes of facilities, including special programs.

B. Reimbursement shall be for routine per diem services, exclusive of ancillary services, except for state-owned facilities where an ancillary per diem rate shall be developed by another State agency, and for county facilities operating under a special agreement with the Department. These ancillary rates are reviewed and audited by the Department and, together with the routine service per diem, form an all-inclusive rate. The routine service per diem shall be based on Medicare principles of reimbursement. Ancillary services for all other facilities are reimbursed separately on a fee for service basis as defined in the California Code of Regulations (CCR), except for facilities providing subacute and pediatric subacute.

subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are:

1. Allied health services ordered by the attending physician, excluding respiratory therapy.
2. Alternating pressure mattresses/pads with motor.
3. Atmospheric oxygen concentrators and enrichers and accessories.
4. Blood, plasma and substitutes.
5. Dental services.
6. Durable medical equipment as specified in Section 51321(g).
7. Insulin.
8. Intermittent positive pressure breathing equipment.
9. Intravenous trays, tubing and blood infusion sets.
10. Laboratory services.
11. Legend drugs.
12. Liquid oxygen system.
13. MacLaren or Pogon Buggy.
14. Medical supplies.
15. Nasal cannula.
16. Osteogenesis stimulator device.
17. Oxygen (except emergency).
18. Parts and labor for repairs of durable medical equipment if originally separately payable or owned by beneficiary.
19. Physician services.
20. Portable aspirator.
21. Portable gas oxygen system and accessories.
22. Precontoured structures (VASCO-PASS, cut out foam).
23. Prescribed prosthetic and orthotic devices for exclusive use of patient.
24. Reagent testing sets.
25. Therapeutic aid fluid support system/beds.
26. Traction equipment and accessories.
27. Variable height beds.
28. X-rays.

For subacute and pediatric subacute levels of care, items can be separately billed as specified in Title 22 CCR, Sections 51511.5(d) and 51511.6(f), respectively.

E. The application of the methodology described in this Attachment, with the most recent update factors and constants used to project costs, is included in an annual rate study conducted by the Department prior to August 1st each year and required by the CCR as an evidentiary base for the filing of new and/or revised regulations. This annual rate study is designated as Supplement 1, and will be provided to the Centers for Medicare and Medicaid Services (CMS) by December 31st of the rate year. The rates will become effective as provided for by the State's Budget Act, typically on August 1 of each year.

F. If a freestanding facility's change in bedsize has an impact on the reimbursement rate, the lesser of the existing rate or the new rate shall prevail until the next general rate change. This is to deter a facility from changing bedsize groupings for the purpose of maximizing reimbursement.

G. Notwithstanding any other provisions of this State Plan, the reimbursement rate shall be limited to the usual charges made to the general public, not to exceed the maximum reimbursement rates set forth by this Plan.

H. Within the provisions of this Plan, the following abbreviations shall apply: NF- nursing facility; ICC/DD-intermediate care facility for the developmentally disabled; ICF/DD-H-intermediate care facility for the developmentally disabled habilitative; ICF/DD-N-intermediate care facility for the developmentally disabled nursing; STP- special treatment program; and DP-distinct part.

I. All long term care providers shall be required to be certified as qualified to participate in the
Medi-Cal program and must also meet the requirements of Section 1919 of the Social Security Act. In order to assure that reimbursement takes into account the cost of compliance with statutory requirements, NFs shall be reimbursed based on the following criteria: (Refer to Table 1 for a specific list)

1. Resident acuity:

NFs shall be reimbursed based on the provision of the following services: level A; level B; subacute – ventilator and non-ventilator dependent; and pediatric subacute -- ventilator and non-ventilator dependent. Level A services are provided to a NF resident who requires medically necessary services of relatively low intensity. Level B, subacute and pediatric subacute

services are provided to a NF resident who requires medically necessary services of varying degrees of higher intensity. The criteria for the acuity of NF services and staffing standards are contained in state regulations and policy manuals.

2. Organization type:

   (a) Freestanding facilities.
   (b) DP/NFs - A distinct part nursing facility is defined as any nursing facility (level A or B) which is licensed together with an acute care hospital.
   (c) Swing-beds in rural acute care facilities.
   (d) Subacute units of freestanding or distinct part NFs - A subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).
   (e) Pediatric subacute units of freestanding or distinct part NFs - A pediatric subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).

3. Bedsize:

   As listed below, in determining the appropriate bedsize categories for reimbursement purposes, a facility's total number of beds shall be used, irrespective of patient acuity level or licensure. A single facility licensed as a distinct part to provide two or more patient acuity levels, or a single facility that has separate licenses for different patient acuity levels, shall have the bedsize for each patient acuity level determined by total beds within the actual physical plant. The bedsize used to establish rates shall be based upon the data contained in the cost report(s) included in the rate study.

   (a) NF level B...1-59, and 60+
   (b) DP/NF level B...no bedsize category
   (c) NF level B/subacute ...no bedsize category
   (d) DP/NF level B/subacute ...no bedsize category
   (e) NF level B/pediatric subacute...no bedsize category

Institutions Code, and Article 1.5 (Provider Audit Appeals) of Title 22, California Code of Regulations. See Appendix 2.

E. When facilities being audited have more than one cost report with an end date in the audit year, the last report will be the one audited, except in those cases where a facility-specific audit adjustment will be applied or actual audited costs are used. In these cases, all cost reports with an end date in the audit year will be audited.

F. All state-operated facilities will be subject to annual audits.

G. Cost reports for nursing facilities that are distinct parts of acute care hospitals may be audited annually.

H. All subacute and pediatric subacute providers will be subject to annual audits.

IV. PRIMARY REIMBURSEMENT RATE METHODOLOGY

Reimbursement rates shall be reviewed by the Department at least annually. Prospective rates for each class shall be developed on the basis of cost reports submitted by facilities. The following method shall be used to determine rates of reimbursement for a class of facilities when cost reports are available:

A. Audit Adjustment.

1. An audit adjustment shall be determined for each of the following classes:

   (a) NF level B field audited facilities with 1-59 beds.
   (b) NF level A field audited facilities with no bedsize category.
   (c) NF level B field audited facilities with 60+ beds.
   (d) ICF/DD field audited facilities with 1-59 beds.
   (e) ICF/DD field audited facilities with 60+ beds.
   (f) ICF/DD-H field audited facilities with combined bedsizes.
   (g) ICF/DD-N field audited facilities with combined bedsizes.

2. Except for DP/NFs and subacute providers, where the audit sample exceeds 80 percent of the universe in a class, the audit adjustment will be applied on a facility-specific basis except that the: (1) class average will be used for unaudited facilities and (2) actual audited costs will be used when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study.

(e) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(i) Addressing a grievance or negotiating or administering a collective bargaining agreement.

(ii) Allowing a labor organization or its representatives access to the provider's facilities or property.

(iii) Performing an activity required by federal or state law or by a collective bargaining agreement.

(iv) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

III. AUDITS

A. Except for DP/NFs, subacute, pediatric subacute, NF-As, ICF/DDs and state-operated facilities, a minimum of 15 percent of cost reports will be field audited by the Department each year. Facilities identified for audit shall be selected on a random sample basis, except where the entire universe of a class is selected for audit. Field audits may be restricted to facilities that have a complete year of reporting. The sample size for each shall be sufficiently large to reasonably expect, with 90 percent confidence, that it will produce a sample audit ratio which varies from the estimated class population audit ratio by not more than two percent. Other facilities may be audited as necessary to ensure program integrity. The results of federal audits, where reported to the State, may also be applied in determining the audit adjustment for the ongoing rate study.

B. The labor data reported by providers shall be audited. In the event that facilities are inconsistently reporting their labor costs in the OSHPD data, the Department will adjust the data utilized to develop the labor index so that the correct amount will be reflected. If the labor data used in developing the labor index is adjusted, the State Plan will be amended to provide the specific methodology for such adjustments.

C. Reports of audits shall be retained by the State for a period of not less than three years, in accordance with 42 CFR 433.32.

D. Providers will have the right to appeal findings which result in an adjustment to program reimbursement or reimbursement rates. Specific appeal procedures are contained in Section 14171 of the Welfare and

SPA 15-025 will delete this appendix. The relevant regulations are cited by reference.

as placement attempts to facilities with a transitional inpatient care contract are documented.

(d) Payment under subsection (a) and (b) shall only be made for services authorized pursuant to conditions set forth in Section 51335.1 for a patient determined to need transitional inpatient care services.

(e) Each provider of transitional inpatient care services shall furnish equipment, drugs, supplies, and services necessary to provide transitional level services except as provided in subsection (d). Such equipment, drugs, supplies, and services are, at a minimum, those which are required by law, including those required by federal Medicaid regulations, and state licensing regulations.

(f) Not included in the per diem reimbursement and to be billed separately by the provider thereof, subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are:

(1) Allied health services, except occupational therapy, physical therapy, speech therapy and respiratory therapy

(2) Blood, plasma, and substitutes

(3) Dental services

(4) DME as specified in Section 51321(g), except suction pumps, IV poles, oxygen and oxygen therapy equipment, excluding ventilators

(5) Decubitus care equipment

(6) Traction equipment and accessories

(7) Hemodialysis

(8) Insulin

(9) Laboratory services

(10) Legend drugs

(11) MacLaren or Pogon Buggy

(12) Medical supplies as specified in Section 59998, except hypodermoclysis sets and intravenous solutions administration sets

(13) Osteogenesis stimulator device

(14) Physician services

(15) Plasmapheresis

(16) Prescribed prosthetic and orthotic devices for exclusive use of patient

(17) Reagent testing sets

(18) X-rays

(g) Not included in the transitional inpatient care per diem reimbursement rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shave or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental.

(h) Payment for leave of absence for the transitional rehabilitation patient authorized in accordance with Section 51335.1(p) shall be made pursuant to Section 51535.

(i) Payment for bedhold authorized in accordance with Section 51335.1(q) shall be made pursuant to Section 51535.1.

(j) Reimbursement to physicians for all medically necessary care provided to transitional inpatient care patients shall be commensurate with those visits to non-transitional acute care patients in general acute care hospitals.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 127000 et seq. Health and Safety Code; and Sections 14105.981 and 14132.22, Welfare and Institutions Code.

HISTORY

1. New section filed 4-1-96 as an emergency; operative 4-1-96 (Register 96, No. 14). A Certificate of Compliance must be transmitted to OAL by 9-30-96 pursuant to Welfare and Institutions Code section 14132.22 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of subsection (b), table, subsection (f), and HISTORY 1 (Register 96, No. 35).
3. New section refiled 9-28-96 as an emergency; operative 9-30-96 (Register 96, No. 55). A Certificate of Compliance must be transmitted to OAL by 1-28-97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9-28-96 order, including amendment of section, transmitted to OAL 1-22-97 and filed 2-10-97 (Register 97, No. 11).

§ 51511.5. Nursing Facility Services—Subacute Care Reimbursement.

(a) The all-inclusive perdiem rates of reimbursement for subacute services as defined in Section 51335.5(a) shall be the lesser of the facility's costs as projected by the Department or the prospective class median rates of:

Type of Licensure	*Type of Patient*	*Rate of Reimbursement*
Hospital-based	Ventilator dependent	[redacted]
Freestanding	Ventilator dependent	[redacted]
Hospital-based	Nonventilator dependent	[redacted]
Freestanding	Nonventilator dependent	[redacted]

(b) Payments to nursing facilities with subacute care units for patients on bedhold receiving acute services shall be in accordance with section 51535.1(d).

(c) The provisions of section 51511 shall apply to subacute care units except for section 51511(a). Section 51511(c) shall apply to subacute providers with the exception of items included within the subacute rate pursuant to section 51511.5(d).

(d) Included within the subacute care per diem rate are all services, equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria including but not limited to:

(1) Oxygen and all equipment necessary for administration including positive pressure apparatus.

(2) Ventilators, including calibration and maintenance.

(3) Feeding pumps and equipment necessary for tube feedings, including formula.

(4) Speech therapy.

(5) Occupational therapy.

(6) Physical therapy.

(7) Equipment and supplies necessary for the care of a tracheostomy.

(8) Lab, X-ray and transportation services.

(9) Equipment and supplies for continuous IV therapy.

(10) Equipment and supplies necessary for debridement, packing and medicated irrigation with or without whirlpool treatment.

(e) For purposes of this section, the rate year is August 1, 1996 through July 31, 1997.

(f) The facility's projected cost shall be based on the audit report findings of cost reports with fiscal periods ending January 1, 1994 through December 31, 1994. In the event that a facility's audit report findings do not include subacute ancillary costs, the facility's projected ancillary cost will be based on the median of the subacute ancillary costs of facilities that had audited ancillary cost.

(g) If the audit of a cost report is not issued by July 1, 1996, the Department shall establish an interim projected reimbursement rate based on the cost report with a fiscal period ending January 1, 1994 through December 31, 1994, adjusted by an audit disallowance factor of .96414.

(h) The Department will use the facility's interim projected reimbursement rate in the computation of the prospective class median rate. In addition, facilities that did not provide subacute care services to Medi-Cal patients during the cost report period and/or facilities with less than a full year's reported cost shall not be used to establish the prospective class median rate.

(i) If the facility has an interim reimbursement rate as specified in (g), when the audit report is issued or when the cost report is deemed true and correct under Welfare and Institutions Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to August 1, 1996 to reflect the cost determined pursuant to such audit, or to reflect the cost in the cost report in the event that cost report is deemed true and correct.

(j) Interest will accrue from August 1, 1996 and be payable on any such underpayment or overpayment at a rate equal to the monthly average received on investment in the Surplus Money Investment Fund (as refer-

enced in the Welfare & Institutions Code Section 14171) during the month the audit report is issued.

(k) If a provider appeals an audit adjustment pursuant to Welfare & Institutions Code Section 14171, and there is a final determination that the audit findings inaccurately reflect the audited facility's projected costs, the provider shall be entitled to seek a retroactive adjustment in its reimbursement rate but the resulting reimbursement rate shall not exceed the prospective median rate as provided in subdivision (a).

(l) Payment under subsection (a) shall only be made for services authorized pursuant to conditions set forth in Section 51355.5 for patients determined to need subacute care services.

NOTE. Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of 1996, Chapter 162, Items 4260-101-0001 and 4260-101-0890.

HISTORY

1. Certificate of Compliance as to 10-27-88 order including amendment of subsection (d) transmitted to OAL 2-24-89 and filed 3-27-89 (Register 89, No. 13). For prior history, see Register 89, No. 1.
2. Amendment filed 8-7-89 as an emergency; operative 8-7-89 (Register 89, No. 32). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 12-5-89.
3. Certificate of Compliance transmitted to OAL 12-1-89 and filed 1-2-90 (Register 90, No. 2).
4. Amendment filed 12-10-90 as an emergency; operative 12-10-90 (Register 91, No. 6). A Certificate of Compliance must be transmitted to OAL by 4-9-91 or emergency language will be repealed by operation of law on the following day.
5. Amendment of subsection (a) and heading filed as an emergency 3-14-91; operative 3-14-91 (Register 91, No. 14). A Certificate of Compliance must be transmitted to OAL by 7-12-91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 12-10-90 order transmitted to OAL 4-8-91 and filed 5-8-91 (Register 91, No. 24).
7. Amendment of subsection (c) and repealer of subsections (e) and (f) filed 5-21-91 as an emergency pursuant to Statutes of 1990, chapter 456, section 36, p. 1658-1659; operative 5-22-91 (Register 91, No. 27). A Certificate of Compliance must be transmitted to OAL by 9-19-91 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 3-14-91 order transmitted to OAL 7-11-91 and filed 8-9-91 (Register 91, No. 50).
9. Amendment of subsection (a) and NOTE filed 8-12-91 as an emergency; operative 8-12-91 (Register 92, No. 6). A Certificate of Compliance must be transmitted to OAL 12-10-91 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 8-12-91 order transmitted to OAL 12-9-91 and filed 1-2-92 (Register 92, No. 18).
11. Amendment of subsection (c) refiled 1-23-92 as an emergency; operative 1-17-92 (Register 92, No. 25). A Certificate of Compliance must be transmitted to OAL 5-22-92 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 1-23-92 order transmitted to OAL 5-22-92 and filed 7-6-92 (Register 92, No. 28).
13. Amendment of subsection (a) and NOTE filed 12-3-92 as an emergency; operative 12-3-92 (Register 92, No. 49). A Certificate of Compliance must be transmitted to OAL 4-2-93 or emergency language will be repealed by operation of law on the following day.
14. Certificate of Compliance as to 12-3-92 order transmitted to OAL 4-2-93 and filed 5-14-93 (Register 93, No. 20).
15. Amendment of subsection (a) and NOTE filed 8-24-93 as an emergency; operative 8-24-93 (Register 93, No. 35). A Certificate of Compliance must be transmitted to OAL by 12-22-93 or emergency language will be repealed by operation of law on the following day.
16. Amendment of subsection (a) and NOTE refiled 12-20-93 as an emergency; operative 12-20-93 (Register 93, No. 52). A Certificate of Compliance must be transmitted to OAL by 4-21-94 or emergency language will be repealed by operation of law on the following day.
17. Certificate of Compliance as to 12-20-93 order transmitted to OAL 3-22-94 and filed 4-28-94 (Register 94, No. 17).
18. Amendment of subsection (a), new subsections (e)-(l) and amendment of NOTE filed 10-16-95 as an emergency; operative 10-16-95 (Register 95, No. 42). A Certificate of Compliance must be transmitted to OAL by 2-13-96 or emergency language will be repealed by operation of law on the following day.
19. Editorial correction of HISTORY 18 (Register 96, No. 6).
20. Amendment of subsection (a), new subsections (e)-(l) and amendment of NOTE refiled 2-5-96 as an emergency; operative 2-5-96 (Register 96, No. 6). A Certificate of Compliance must be transmitted to OAL by 6-6-96 or emergency language will be repealed by operation of law on the following day.
21. Certificate of Compliance as to 2-5-96 order transmitted to OAL 6-4-96 and filed 7-12-96 (Register 96, No. 28).
22. Amendment of subsections (a), (e)-(g) and (i)-(j) and NOTE filed 9-19-96 as an emergency; operative 9-19-96 (Register 96, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-17-97 or emergency language will be repealed by operation of law on the following day.
23. Certificate of Compliance as to 9-19-96 order transmitted to OAL 1-17-97 and filed 3-3-97 (Register 97, No. 10).

§ 51511.6. Nursing Facility Services — Pediatric Subacute Care Reimbursement.

(a) The per diem rates of reimbursement for pediatric subacute services as defined in Section 51335.6(a) shall be as follows:

Licensure	*Type of Patient*	*Effective Until 7/31/97 for Alameda, Contra Costa Marin, San Francisco, San Mateo, Santa Clara Counties*	*Effective Until 7/31/97 for All Other Counties*	*Effective on 8/1/97 Statewide*
Hospital Based	Ventilator Dependent	[redacted]		
Hospital Based	Non Ventilator Dependent	[redacted]		
Free standing	Ventilator Dependent	[redacted]		
Free standing	Non-Ventilator Dependent	[redacted]		

(b) The per diem rate of reimbursement for supplemental rehabilitation therapy services shall b[redacted] This rate shall include payment for physical therapy, occupational therapy and speech therapy services provided in accordance with Section 51215.10(i) through (m).

(c) The per diem rate of reimbursement for ventilator weaning services shall be [redacted] This rate shall include respiratory care practitioner and nursing care services provided in accordance with Section 51215.11.

(d) Payment to nursing facilities with pediatric subacute units for patients on bedhold receiving acute services shall be in accordance with Section 51535.1(d).

(e) The provisions of Section 51511 shall apply to pediatric subacute units except for Section 51511(a). Section 51511(c) shall apply to pediatric subacute units except as provided for in 51511.6(f).

(d) The pediatric subacute per diem rate includes the following:

(1) Equipment and supplies necessary for continuous intravenous therapy;

(2) Oxygen and all equipment necessary for administration including positive pressure apparatus;

(3) Ventilators, including calibration and maintenance;

(4) Registered Dietician consultant services;

(5) Respiratory therapy services;

(6) Physical, occupational and speech therapy services, as specified in Section 51215.10(b);

(7) Developmental services;

(8) Service Coordinator activities.

NOTE. Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of 1996, Chapter 162, Items 4260-101-0001 and 4260-101-0890.

HISTORY

1. New section filed 4-13-94 as an emergency; operative 4-1-94. Emergency adoption submitted to OAL for printing only pursuant to section 4, AB 36 (chapter 1030, Statutes of 1993) (Register 94, No. 15).
2. Certificate of Compliance as to 4-13-94 order including amendment of section transmitted to OAL 9-26-94 and filed 10-20-94 (Register 94, No. 42).
3. Editorial correction of subsection (d)(3) and HISTORY 1 and 2 (Register 95, No. 14).
4. Amendment of subsection (a) and NOTE filed 9-19-96 as an emergency; operative 9-19-96 (Register 96, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-17-97 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 9-19-96 order transmitted to OAL 1-17-97 and filed 3-3-97 (Register 97, No. 10).
6. Amendment of section and NOTE filed 6-30-97 as an emergency; operative 6-30-97 (Register 97, No. 27). A Certificate of Compliance must be transmitted to OAL by 10-28-97 or emergency language will be repealed by operation of law on the following day.

LONG TERM CARE (LTC) CLASSES TO BE USED FOR RATE-SETTING PURPOSES

PATIENT ACUITY LEVELS	*ORGANIZATION TYPE*	*No. of Beds*	*Geographical Location*	*Reimbursement Basis*
NF LEVEL B	-Distinct part NF	All	Statewide	*
	-Freestanding NF	1-59	Los Angeles Co.	Median
(EXCEPT SUBACUTE AND		1-59	Bay Area**	Median
PEDIATRIC SUBACUTE.)		1-59	All Other Counties	Median
		60+	Los Angeles Co.	Median
		60+	Bay Area**	Median
		60+	All Other Counties	Median
SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	*
NON-VENTILATOR	-Distinct part NF	All	Statewide	*
DEPENDENT	-Freestanding NF	All	Statewide	*
PEDIATRIC SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NON-VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NF LEVEL A	-All	All	Los Angeles Co.	Median
		All	Bay Area**	Median
		All	All Other Counties	Median
		All	Statewide	***
ICF/DD	-All	1-59	Statewide	65th percentile
		60+	Statewide	65th percentile
ICF/DD-Hs and Ns	-All	4-6	Statewide	65th percentile
		7-15	Statewide	65th percentile
RURAL SWING-BED NF LEVEL B SERVICES	-Rural acute hospitals	All	Statewide	Median

*DP/NF level Bs and Subacute providers are reimbursed at either the lesser of costs as projected by the Department or the prospective median rate of the LTC class.
**Bay area is defined as San Francisco, San Mateo, Marin, Napa, Alameda, Santa Clara, Contra Costa, and Sonoma counties.
***Current rate increased by the same percentage rate as received by other NF level A's.