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 SOCIAL SERVICES
 HEALTH
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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 will be 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. This legislation will become inoperative on July 31, 2008. Provisions of AB 1629 mandate that the new facility-specific rates during rate years 2005/06 and 2006/07, shall not be less than the rate methodology in effect as of July 31, 2005. 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, pediatric subacute and transitional care.

TN 05-005
 Supersedes
 TN 01-022

SEP - 9 2005

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- C. The routine service per diem includes all equipment, supplies and services necessary to provide appropriate nursing care to long-term care patients or intermediate care for the developmentally disabled, except those items listed as separately payable or personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility as part of patient care and periodic hair cuts), and television rental.

- D. Not included in the payment rate and to be billed separately by the provider thereof,

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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, pediatric subacute, and transitional levels of care, items can be separately billed as specified in Title 22 CCR, Sections 51511.5(d), 51511.6(f) and 51511.3(f) respectively (see Appendix 4).

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- 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; ICF/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; pediatric subacute -- ventilator and non-ventilator dependent; and transitional inpatient care -- rehabilitative and medical. Level A services are provided to a NF resident who requires medically necessary services of relatively low intensity. Level B, subacute, pediatric subacute, and

transitional inpatient care 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).
- (f) Transitional inpatient care units of freestanding or distinct part NFs -- A transitional inpatient 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

TN 01-022
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TN 01-012

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- (f) DP/NF 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
- (m) Transitional inpatient care...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, transitional inpatient care, 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 a 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 systems 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

requirements.

2. Each facility shall retain its supporting financial and statistical records for a period of not less than three years following the date of submission of its cost report and shall make such records available upon request to authorized state or federal representatives.
3. All cost reports received by the State shall be maintained for a period of not less than five years following the date of submission of reports, in accordance with 42 CFR 433.32.
4. Cost reports for freestanding facilities shall be included in the rate study even though they may contain more or less than 12 months and/or more than one report, as long as the fiscal periods all end within the time frame specified for the universe being studied. Only cost reports accepted by the Office of Statewide Health Planning and Development (OSHPD) shall be included in the rate study.
5. For DP/NFs and subacute providers, only cost reports formally accepted by the Department with 12 or more months of DP/NF or subacute costs shall be used in the rate study to determine the median facility rate. For purposes of the median determination, only DP/NFs with Medi-Cal patient days accounting for 20 percent or more of their total patient days shall be included.
6. The State reserves the right to exclude any cost report or portion thereof that it deems to be inaccurate, incomplete or unrepresentative.
7. Freestanding STP facilities are excluded from the determination of freestanding NF rates due to their different staffing requirements and the complexity of their reporting costs by level of care and services. The cost reports for these facilities often comingle the data related to NF, Short-Doyle and special county programs.
8. NF Level A rates shall be established on the basis of costs reported by facilities that only provided that level of care during the cost report period.
9. The universe of facilities used to establish the prospective freestanding rates shall be provided by OSHPD on hard copy and tapes. In the case that an error

TN 01-022
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or oversight is discovered or brought to the State's attention, which would create an inequity, the Department would adjust rates in the following year to compensate providers for the error. Such an adjustment would normally be in the form of an add-on. (See paragraph IV.C, below.)

10. Where identified, facilities that have switched their level of care (e.g., ICF/DD to NF Level B) will not be used to establish rates if their cost report does not reflect their current status.
11. Where identified, facilities that have terminated from the program will be excluded from the rate studies.
12. When ICF/DD-H and N providers erroneously report calendar days instead of patient days on their cost reports, the State will contact the provider for the correct information to be used in the rate study.

B. The Department shall determine reasonable allowable costs based on Medicare reimbursement principles as specified in 42 Code of Federal Regulations (CFR) Part 413. The exceptions to this provision are:

1. The Deficit Reduction Act of 1984 (DEFRA) requires the Department to recognize depreciation only once for reimbursement purposes when a change of ownership has occurred after July 18, 1984. Since the Department reimburses long term care providers using a prospective rate methodology, the Department shall use the net book value approach in lieu of recapturing depreciation to ensure that depreciation is recognized only once for reimbursement purposes. The net book value approach is defined as follows:

Net book value means that when a change of ownership occurs after July 18, 1984, the asset sold shall have a depreciable basis to the new owner that is the lesser of the: acquisition cost of the new owner; or historical cost of the owner of record as of July 18, 1984, less accumulated depreciation to the date of sale (or in the case of an asset not in existence as of July 18, 1984, the acquisition cost less accumulated depreciation to the date of sale of the first owner of record after July 18, 1984).

2. For developmentally disabled and psychiatric patients in state owned facilities, appropriate personal clothing in lieu of institutional gowns or pajamas are an allowable cost.

TN 01-022
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TN 01-012

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3. For purposes of determining reasonable compensation of facility administrators, pursuant to Chapter 9 of the CMS Provider Reimbursement Manual (HIM 15) – reproduced in full at Paragraph 5577 of the CCH Medicare and Medicaid Guide, the State shall conduct its own survey. Based on the data collected from such surveys, the State shall develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those facilities.

For purposes of this section, “facilities” are defined as: acute care, long term care (skilled nursing, intermediate care, intermediate care for the developmentally disabled, intermediate care for the developmentally disabled habilitative and nursing), Federally Qualified Health Centers, and Rural Health Clinics.

4. (a) Allowable costs shall not include provider expenditures to assist, promote, or deter union organizing to the extent such expenditures are paid by the provider with State funds. Definitions applicable to this paragraph 4 are set forth below in subparagraphs (b) and (c).
- (b) “Assist, promote, or deter union organizing” means any attempt by the provider to influence the decision of its employees in California, or the California employees of its subcontractors, regarding either of the following:
- (i) Whether to support or oppose a labor organization that represents or seeks to represent employees.
 - (ii) Whether to become a member of any labor organization.
- (c) “State funds” means California State Treasury funds or California State special or trust funds received by the provider on account of the provider’s participation in a California state program. If State funds and other funds are commingled, any expenditures to assist, promote, or deter union organizing shall be allocated between State funds and other funds on a pro rata basis.
- (d) Any costs, including legal and consulting fees and salaries of supervisors and employees, incurred for research for, or preparation, planning, or coordination of, or carrying out, an activity to assist, promote, or deter union organizing shall be treated as paid or incurred for that activity.

- (c) 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, transitional inpatient care units, 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 five 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

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.
- I. All transitional inpatient care units may 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.

3. For DP/NFs and subacute providers, actual audited costs will be used to determine the facility's prospective rate when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study. If the field audit of the cost report used in the study is not available by July 1, then an interim rate shall be established by applying the field audit adjustment of the NF level Bs with 60+ beds to the cost report. If a facility has an interim reimbursement rate, when the audit report that matches the cost report is issued or the cost report is deemed true and correct under W&I Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to the beginning of the rate year to reflect these costs, not to exceed the maximum rate as set forth in Section IV.E. Interest shall accrue and be payable on any underpayments or overpayments resulting from such adjustment. Medicare standards and principles of cost reimbursement shall be applied when auditing DP/NFs (see 42 CFR Part 413).
4. As a result of the appeal process mentioned in III.D., some audit findings may be revised. Except for DP/NFs and subacute, the audit adjustment for the current year shall incorporate any revisions resulting from a decision on an audit appeal. The Department shall consider only the findings of audit appeal reports that are issued more than 180 days prior to the beginning of the new rate year.

For DP/NFs or subacute providers, excluding pediatric subacute, that obtain an audit appeal decision that the facility-specific audit adjustment on which a DP/NF or subacute rate is based inaccurately reflects the facility's projected costs, the facility shall be entitled to seek a retroactive adjustment in their prospective reimbursement rate, not to exceed the maximum DP/NF or subacute rate, as set forth under Section IV (E)(1), (10) and (11).

5. Audited costs will be modified by a factor reflecting share-of-cost overpayments in the case of class audit adjustments.
 6. The results of federal audits, when reported to the state, may be applied in determining audit adjustments.
- B. Adjustment for facilities which provide a different type of service from the remainder of the class.

Additional amounts, where appropriate, shall be added to the payment rates of individual facilities in a class to reimburse the costs of meeting

requirements of state or federal laws or regulations including the costs of special programs.

C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal laws and regulations which would impact upon such costs. These adjustments will be reflected as an "add-on" to the rates for these costs and, where appropriate, an "add on" may be used to reflect other extraordinary costs experienced by intermediate care facilities for the developmentally disabled (including habilitative and nursing facilities for the developmentally disabled). Add ons for extraordinary costs shall not be considered for other categories of long term care providers. To the extent not prohibited by federal law or regulations, "add-ons" to the rate may continue until such time as those costs are included in cost reports used to set rates under this state plan.

For example, state or federal mandates may include such costs as changes to the minimum wage or increases in nurse staffing requirements. An example of other extraordinary costs might include unexpected increases in workers compensation costs or other costs which would impact facilities ability to continue to provide patient care.

A brief description of all add-ons included in the current year's rate study will be provided to HCFA by December 31st of the rate year, as a part of Supplement 1.

D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.
2. An index developed from the most recent historical data in the long term care industry as reported to OSHPD by providers.

The update factors used by the Department shall be applied to all classes from the midpoint of each facility's fiscal period to the midpoint of the State's rate year in which the rates are effective.

E. Cost-of-Living Update

Adjusted costs for each facility are updated from the midpoint of the facility's report period through the midpoint of the State's Medi-Cal rate year

Adjusted costs are divided into categories and treated as follows:

1. Fixed or Capital-Related Costs - These costs represent depreciation, leases and rentals, interest, leasehold improvements, and other amortization. No update is applied.
2. Property Taxes - These costs, where identified, are updated at a rate of 2 percent annually, converted to 0.1652 percent per month. Some facilities do not report property taxes---either because they are nonprofit and exempt from such tax or because they have a lease or rental agreement that includes those costs.
3. Labor Costs - A ratio of salary, wage, and benefits (SWB) costs to the total costs of each facility is used to determine the amount of the labor cost component to be updated. The ratio is determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report, and adding costs that represent all wage-related benefits, including vacation and sick leave.

The labor costs for ICF/DD-Hs and ICF/DD-Ns are facility-specific, obtained directly from each cost report in the study. Labor costs for each facility are updated from the midpoint of its cost reporting period to the midpoint of the State's rate year.

4. All Other Costs - These costs are the total costs less fixed or capital-related costs, property taxes, and labor costs. The update for this category utilizes the California Consumer Price Index (CCPI) for "All-Urban Consumers" and figures projected by the State Department of Finance.

F. The reimbursement rate per patient day shall be set at the median of projected costs for the class, as determined above, except that:

1. NF-B services, excluding subacute and pediatric subacute, which are provided in distinct parts of acute care hospitals, shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate.
2. NF-A services provided in distinct parts of acute care hospitals shall be reimbursed at the applicable NF-A rate for freestanding facilities in the same geographical area location.
3. Rural hospitals are identified each year by OSHPD. For those rural hospitals with Medi-Cal distinct part nursing facility days, their rates, as determined for the DP/NF-B level of care, are arrayed and the median rate is applied to all rural swing bed days. Facilities that report no Medi-Cal days, have an interim rate, or

submit only a partial year cost report are excluded from the swing bed rate calculation.

4. NF services provided in a facility which is licensed together with an acute care hospital under a single consolidated license, yet fails to meet the definition of a DP/NF, shall be reimbursed at the applicable rate for freestanding facilities.
5. As long as there is a projected net increase in the California Consumer Price Index during the State's fiscal year previous to the new rate year, no prospective rate of reimbursement shall be decreased solely because the class median projected cost is less than the existing rate of reimbursement. In the event the existing prospective class median is adopted as the maximum reimbursement rate for DP/NF-Bs and subacute units providers with projected costs below the existing class median shall be reimbursed their projected costs as determined in the most recent rate study.

In the event there are components in the previous rate study that increased the reimbursement rate to compensate for time periods prior to the effective date of the rates, the rates shall be adjusted (for purposes of determining the existing rate) to reflect the actual per diem cost without the additional compensation. As an example, assume that the per diem cost of a new mandate was \$.10. The new mandate was effective June 1, 1997, but the rates were not implemented until August 1, 1997. The rates would include an add-on of \$.117 (\$.10 times 14 months, divided by 12 months) to compensate 14 months add-on over a 12 month rate period.

6. If a DP, formerly licensed as a freestanding facility, has costs less than the freestanding median rate for their group, their rate will not be reduced to less than the median solely because of the change to distinct part licensure.
7. DPs in areas where there are excess freestanding beds may accept patients at the area's highest NF-B rate to assure greater access to Medi-Cal patients and to provide a savings to the program.
8. State operated facilities shall be reimbursed their costs as reflected in their cost reports, in accordance with the provisions of this plan, using individual audit data for adjustments. These costs are not to be included in the calculation of the class median rate for all other DP/NF level Bs.

9. ICF/DDs (except state operated facilities), ICF/DD-H and ICF/DD-N facilities will be reimbursed at the 65th percentile, instead of the median, in recognition of the fact that they serve a disproportionate share of low income patients with special needs.
10. Subacute services which are provided in both distinct parts of acute care hospitals and freestanding NFs shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate, broken down by ventilator and non-ventilator and DP or freestanding NF.
11. The subacute rate includes additional ancillary costs. Where available, the facility's projected cost is based on the audited ancillary cost data. In the event that audited ancillary costs are not available, the facility's projected cost is based on the median of the projected subacute ancillary costs of the facilities in the study that have audited ancillary costs.
12. For purposes of setting the DP/NF or subacute prospective class median rate, the Department shall use the facility's interim projected reimbursement rate when their audit report is not issued as of July 1st.
13.
 - (a) For the rate year 2002-03, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2002-03 rate year, had its subacute prospective reimbursement rate for 2002-03 set at its 2001-02 rate. The facility's 2002-03 subacute prospective reimbursement rate was no more than the 2002-03 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.
 - (b) For the rate year 2003-04, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2003-04 rate year, had its subacute prospective reimbursement rate for 2003-04 set at its 2002-03 rate. The facility's 2003-04 subacute prospective reimbursement rate was no more than the 2003-04 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.
 - (c) For the rate year 2005-06, and each rate year thereafter, a DP/NF subacute facility that experiences a reduction in costs in the previous rate year, which would result in a reduced reimbursement rate for the current rate year, will have its prospective reimbursement rate for the current rate year established at the reimbursement rate for the previous rate year. For example, if a DP/NF subacute facility's 2006-07 prospective reimbursement rate was less than the DP/NF subacute's 2005-06 prospective reimbursement rate, the DP/NF subacute's reimbursement rate for the 2006-07 rate year will be established at its 2005-06 prospective reimbursement rate. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

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14. Any facility that has been a NF-A 100+ bedsize facility will no longer have its reimbursement rate adjusted at the same percentage increase as other NF-level As. Its reimbursement rate will be based on the applicable methodology described in this Section IV paragraph F.
15. (a) Nursing facilities and other specified facilities as identified in Section 14110.65 of the Welfare and Institutions Code, will be eligible to request and receive a supplemental rate adjustment when the facility meets specific requirements.

(b) In order to qualify for the rate adjustment, the facility must have a verifiable written collective bargaining agreement or other legally binding, written commitment to increase non-managerial, non-administrative, and non-contract salaries, wages and/or benefits that complies with Section 14110.65 of the Welfare and Institutions Code and regulations adopted pursuant thereto.

(c) Except as provided in subparagraph (d) below, the rate adjustment will be equal to the Medi-Cal portion (based on the proportion of Medi-Cal paid days) of the total amount of any increase in salaries, wages and benefits provided in the enforceable written agreement referenced in subparagraph (b). This amount will be reduced by an increase, if any, provided to that facility during that rate year in the standardized rate methodology for labor related costs (see Section LE of this state plan) attributable to the employees covered by the commitment. A rate adjustment made to a particular facility pursuant to this subparagraph 15 will only be paid for the period of the non-expired, enforceable, written agreement. The Department will terminate the rate adjustment for a specific facility if it finds the binding written commitment has expired and does not otherwise remain enforceable.

(d) A rate adjustment under this subparagraph 15 will be no more than the greater of 8 percent of that portion of the facility's per diem labor costs, prior to the particular rate year (August 1st through July 31st), attributable to employees covered by the written commitment, or 8 percent of the per diem labor costs of the peer group to which the facility belongs, multiplied by the percentage of the facility's per diem labor costs attributable to employees covered by the written commitment.

(e) The payment of the rate adjustment will be subject to certification of the availability of funds by the State Department of Finance by May 15 of each year and subject to appropriation of such funds in the State's Budget Act.

TN 03-041
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TN 03-027

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(f) This subparagraph 15 will become effective as of the first day of the month following the date that this provision is approved by the Centers for Medicare and Medicaid Services.

16. (a) Hospice care rates apply to four basic levels of care: Routine Home Care, Continuous Home Care, Inpatient Respite Care, and General Inpatient Care. Each year after the end of the Federal fiscal year (September 30), the Centers for Medicare & Medicaid Services provides the Department of Health Services with the new Medicare rates and the wage indices for the various groupings of California counties. Each Medicare rate for the services referenced above consists of a wage and non-wage component. The wage component of each Medicare rate is multiplied by the wage index for each county grouping and the result is added to the non-wage component to arrive at the reimbursement rate for hospice care services rendered within the particular county grouping. These rates are effective from October 1 through September 30 of each year.

(b) Effective January 3, 2004, in addition to the reimbursement for the services referenced in (a) above, payment to facilities for room and board services shall be made at 95 percent of the Medi-Cal facility rate where the patient resides, if the facility is classified as one of the following: Nursing Facility Level B, Nursing Facility Level A, Intermediate Care Facility - Developmentally Disabled, Intermediate Care Facility - Developmentally Disabled, Rehabilitative, Intermediate Care Facility - Developmentally Disabled, Nursing.

- G. Notwithstanding paragraphs A through E of this Section, in the five situations described below, DP/NF-Bs will receive an interim per diem rate established by the Department. The interim rate will be based on the DP/NF-B's estimate of its total patient days and costs, including the patient days and costs associated with the additional beds that are added. The interim rate established by the Department will not exceed the applicable DP/NF-B median rate for the particular rate year. This provision applies to the following situations:

1. A general acute care hospital (GACH) without a DP/NF-B acquires a previously licensed freestanding NF-B and converts it to newly approved DP/NF-B.
2. A GACH with a DP/NF-B merges with another GACH with a DP/NF-B and consolidates all beds under one existing license.
3. A GACH with a DP/NF-B consolidates a freestanding NF-B into one existing license.
4. Any instance, which results in the creation of a Composite DP/NF-B, as defined in 42 Code of Federal Regulations section 483.5(c) which refers to a facility with one license, one provider agreement, and one provider number.
5. A GACH forms a newly licensed DP/NF-B.

The interim per diem rate and supplementation under Section VIII will be effective upon the date the Department issues a consolidated license or adds the additional beds to the hospital's current license. When DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-B's final

- 2. A GACH with a DP/NF-B merges with another GACH with a DP/NF-B and consolidates all beds under one existing license.
- 3. A GACH with a DP/NF-B consolidates a freestanding NF-B into one existing license.
- 4. Any instance, which results in the creation of a Composite DP/NF-B, as defined in 42 Code of Federal Regulations section 483.5(c) which refers to a facility with one license, one provider agreement, and one provider number.

IN 06-004
Supersedes
IN 03-041

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Newly licensed DP/NF-Bs without historical costs of providing NF-B services shall receive an interim reimbursement rate. This interim rate shall be based on the DP/NF-B's projection of their total patient days and costs, as approved by the Department. When actual DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-Bs final prospective rate. Final DP/NF-B rates may be less than the interim rate, in which case the Department shall recover any overpayment.

- H. DP/NF subacute providers that do not have historical costs shall receive an interim reimbursement rate. This interim rate shall be based on the facility's projection of their total patient days and costs, as approved by the Department. When twelve or more months of actual DP/NF subacute audit report data becomes available, interim rates will be retroactively adjusted to the facility's final prospective rate. Final rates may be less than the interim rate, in which case the Department shall recover any overpayment. Only DP/NF subacute providers participating in the program as of June 1st will be included in the rate study.

- I. Notwithstanding Paragraphs A. through G. of this Section, San Mateo County Hospital shall receive an interim reimbursement rate for the skilled nursing facility located at 1100 Trousdale Drive in Burlingame, California. The interim rate will be effective on August 1, 2003 and will be equal to the hospital DP/NF rates of its existing DP/NF skilled nursing facility located at 222 West 39th Avenue in San Mateo, California. The interim rate will apply through July 31, 2006.

- J. In accordance with Section 14105.06 of the Welfare and Institutions Code and notwithstanding paragraphs A through F of this Section, all Medi-Cal long-term care facility rates that went into effect August 1, 2003, will remain unchanged through July 31, 2005, and be in effect for the period August 1, 2003, through July 31, 2005. This provision applies to all long-term care facility types (except those operated by the State), including the following:
 - 1. Freestanding nursing facilities licensed as either of the following:
 - (a) An intermediate care facility pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.
 - (b) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code.

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TN 04-006

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2. A skilled nursing facility that is a distinct part of a general acute care hospital as defined in Section 72041 of Title 22 of the California Code of Regulations.
3. A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.
4. An adult day health care center.

V. DETERMINATION OF RATES FOR NEW OR REVISED PROGRAMS

- A. When the State adopts a new service or significantly revises an existing service, the rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.
- B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study. After five years from the end of the fiscal year in which a facility begins participating in a program for Medical reimbursement, the reimbursement rate methodology will either revert to the provisions described in Section I through IV of Attachment 4.19-D or be subject to new provisions as described in a State Plan amendment.

TN 03-041
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TN 03-027

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3/17/04

Effective Date

January 3, 2004

VI. DP/NF SERVICES SUPPLEMENTAL REIMBURSEMENT PROGRAM

This program provides supplemental reimbursement for a DP/NF of a general acute care hospital or an acute psychiatric care hospital, which meets specified requirements and provides a large proportion of nursing facility services to Medi-Cal beneficiaries.

Supplemental reimbursement is available for the costs associated with the construction, renovation, expansion, remodel, or replacement of an eligible facility, and would be in addition to the rate of payment the facility receives for nursing facility services under the current DP/NF reimbursement methodology.

A. Definition of an Eligible Project

1. Projects eligible for supplemental reimbursement under this program will include any new capital projects for which final plans have been submitted to the appropriate review agency after January 1, 2000, and before July 1, 2001, or as permitted by subsequent legislation that changes the final plan submission date.
2. "Capital project" means the construction, expansion, replacement, remodel, or renovation of an eligible facility, including buildings and fixed equipment. A "capital project" does not include furnishings or items of equipment that are not fixed equipment.
3. Capital projects receiving funding under this program will include the upgrade or construction of buildings and equipment only to a level required by the most current accepted medical practice standards, including projects designed to correct Joint Commission on Accreditation of Hospitals and Health Systems, fire and life safety, seismic, or other federal and state related regulatory standards.

B. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity had all of the following additional characteristics during the entire 1998 calendar year:

1. Provided services to Medi-Cal beneficiaries;
2. Was a DP/NF of an acute care hospital providing nursing facility care;

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3. Had not less than 300 licensed nursing facility beds;
4. Had an average nursing facility Medi-Cal patient census of not less than 80 percent of the total nursing facility patient days; and
5. Was owned by a county, or city and county.

C. Supplemental Reimbursement Methodology

Supplemental reimbursement provided by this program will be distributed under a payment methodology based on nursing facility services provided to Medi-Cal patients at the eligible facility. An eligible facility's supplemental reimbursement for a capital project qualifying for this program will be calculated and paid as follows:

1. For any fiscal year the facility is eligible to receive supplemental reimbursement, the facility will report to the Department the amount of debt service on the revenue bonds or other financing instruments issued to finance the capital project. This amount represents the gross total amount to be considered for supplemental reimbursement. The gross total amount will be reduced by all other funds received by an eligible county or city and county for the purpose of construction/renovation of an eligible project.
2. Only those projects, or portions thereof, that are available and accessible to Medi-Cal beneficiaries will be considered for supplemental reimbursement, and such supplemental reimbursement will only be made for capital projects, or for that portion of capital projects, which provide nursing facility services and qualifies for reimbursement according to applicable Medicare reimbursement principles.

Capital project expenditures for an eligible facility are those expenditures which, under generally accepted accounting principles, are not properly chargeable as expenses of operation and maintenance and are related to the acquisition, construction, renovation, improvement, modernization, expansion, or replacement of a plant, buildings, and equipment with respect to which the expenditure is made, including, but not limited to the following, if included in revenue bond debt service: (1) studies, surveys, designs, plans, working drawings, and specifications bid preparation, inspection, and material testing; (2) site preparation, including demolishing or razing structures, hazardous waste removal, and grading and paving; and (3) permit and license fees.

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claimed expenditures for the capital project are eligible for federal financial participation.

3. In order to fully disclose reimbursement amounts to which the eligible facility may be entitled, the county, or city and county is required to keep, maintain, and have readily retrievable, records as specified by the Department. Such records include, but are not limited to, construction and debt service costs.
4. Prior to receiving supplemental reimbursement an eligible hospital must submit to the Department a copy of the certificate of occupancy for the capital project.
5. Prior to paying any supplemental reimbursement, the Department will require the county, or city and county, to disclose all public and private funds it receives for the purpose of financing the capital project.
6. Any and all funds expended pursuant to this program are subject to review by the Department. The Department will review, on a semiannual basis, the special account where all payments received by an eligible facility are placed and used exclusively for the debt service on an eligible project to verify that funds are used exclusively for the payment of appropriate expenses related to the eligible capital project.

E. Standards for Supplemental Reimbursement

1. The Department will require that any county, or city and county, receiving supplemental reimbursement under this program enter into a written interagency agreement with the Department for the purpose of implementing this program.
2. Supplemental reimbursement paid under this program must not duplicate any reimbursement received by an eligible facility for construction costs that would otherwise be eligible for reimbursement for nursing facility services under the DP/NF reimbursement methodology specified in this Attachment.
3. The total Medi-Cal reimbursement received by a facility eligible under this program will not result in a reduction of the rate of payment the facility

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receives for nursing facility services under the most current DP/NF reimbursement methodology.

4. The supplemental reimbursement provided by this program will not commence prior to the date the hospital submits to the Department a copy of the certificate of occupancy for the capital project.
5. All payments received by an eligible facility must be placed in a special account; the funds in the special account will be used exclusively for the payment of expenses related to the eligible capital project.
6. Supplemental reimbursement will be equal to the amount of federal financial participation received for the claims submitted by the Department for debt service expenditures allowable under federal law.
7. In no instance will the total amount of supplemental reimbursement received under this program combined with that received from all other sources dedicated exclusively to debt service, exceed 100 percent of the debt service for the capital project over the life of the loan, revenue bond, or other financing mechanism.
8. A facility qualifying for and receiving supplemental reimbursement pursuant to this program will continue to receive reimbursement: (i) until the qualifying loan, revenue bond, or other financing mechanism is paid off; and (ii) as long as the facility's eligible capital project continues to provide nursing facility services and is available and accessible to Medi-Cal patients.
9. The state share of the debt service amount submitted to the Federal Health Care Financing Administration for purposes of supplemental reimbursement will be: (i) paid with only county, or only city and county funds; and (ii) certified to the state as specified in paragraph D. 2. above.
10. Total Medicaid reimbursement provided to an eligible facility will not exceed applicable federal upper payment limits.

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VII. PUBLIC CONSIDERATION

- A. A public comment period is provided, during which a public hearing may be requested by interested parties. During this period, the evidentiary base and a report of the study methodology and findings are available to the public.
1. Interested parties will be notified of the time and place of the hearing (if scheduled), and the availability of proposed rates and methodologies by direct mail and public advertising in accordance with state and federal law.
 2. Comments, recommendations, and supporting data will be received during the public comment period and considered by the Department before certifying compliance with the state Administrative Procedures Act.
 3. As part of the final regulation package, the Department will respond to all comments received during the public comment period concerning the proposed changes.

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TN 01-012

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VIII. PUBLIC HOSPITAL DP/NF ADDITIONAL REIMBURSEMENT

This program provides additional reimbursement for a DP/NF of a general acute care hospital that is owned or operated by a city, county, city and county, or health care district, which meets specified requirements and provides nursing facility services to Medi-Cal beneficiaries.

Additional reimbursement under this program is available only for the federal share of costs that are in excess of the rate of payment the facility receives for nursing facility services under the current DP/NF reimbursement methodology and any other source of Medi-Cal reimbursement for DP/NF services.

A. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity continuously has all of the following additional characteristics during the Department's rate year beginning August 1, 2001, and subsequent rate years:

1. Provides services to Medi-Cal beneficiaries.
2. Is a DP/NF of an acute care hospital providing nursing facility care. For purposes of this section, "acute care hospital" means the facilities described at subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.
3. Is owned or operated by a city, county, city and county, and/or health care district organized pursuant to Chapter 1 of Division 23 (commencing with Section 32000) of the Health and Safety Code.

Owners of eligible facilities must provide certification to the state that the amount claimed by them is eligible for federal financial participation.

B. Additional Reimbursement Methodology

Additional reimbursement provided by this program to an eligible nursing facility is intended to allow federal financial participation for certified public expenditures.

1. As described in paragraph A, the expenditures certified by the local agency to the state shall represent the payment

eligible for federal financial participation. Allowable certified public expenditures shall determine the amount of federal financial participation.

2. In no instance shall the amount certified pursuant to paragraph C.1 , when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of the projected costs (as determined pursuant to Sections I through V of this Attachment 4.19-D) for DP/NF services at each facility.
3. Costs associated with the provision of subacute services pursuant Section 14132.25 of the Welfare and Institutions Code will not be certified for reimbursement pursuant to this section.
4. The additional Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on skilled nursing services provided to Medi-Cal patients at the eligible facility. The provider shall report to the Department, on a quarterly basis, the amount of the eligible costs that are the lesser of actual costs or the Department's projected costs for that facility. In no case shall total annual reimbursement under this section exceed the Department's projected costs.

C. Facility Reporting Requirements

The governmental entity reporting on behalf of any eligible facility must do all of the following:

1. Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for DP/NF services are eligible for federal financial participation.
2. Provide evidence supporting the certification as specified by the Department.
3. Submit data as specified by the Department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

4. Keep, maintain and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the Centers for Medicare and Medicaid Services.

D. Standards for Additional Reimbursement

1. The Department may require that any city, county, city and county, or health care district receiving additional reimbursement under this program enter into a written interagency agreement with the Department for the purposes of implementing this program.
2. Additional reimbursement paid under this program must not be greater than the difference between total projected Medi-Cal costs and the amount paid under the existing DP/NF reimbursement methodology specified in Sections I through V of this state plan.
3. The total Medi-Cal reimbursement received by a facility eligible under this program will in no instance exceed 100 percent of the projected costs (as determined pursuant to Sections I through V of this state plan) for DP/NF services at each facility.

E. Department's Responsibilities

1. The Department will submit claims for federal financial participation for the expenditures for services that are allowable expenditures under federal law.
2. The Department will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.
3. The state share of the additional reimbursement under this program will be equal to the amount of the federal financial participation of eligible expenditures paid by city, county, city and county and/or health care district funds and certified to the state as specified in Section C.1 above.

4. Total Medicaid reimbursement provided to an eligible facility will not exceed applicable federal upper payment limits.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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TN _____

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Effective Date August 1, 2001

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

<u>PATIENT ACUITY LEVELS</u>	<u>ORGANIZATION TYPE</u>	<u>No. of Beds</u>	<u>Geographical Location</u>	<u>Reimbursement Basis</u>
NF LEVEL B (EXCEPT SUBACUTE, PEDIATRIC SUBACUTE, and TRANSITIONAL INPATIENT CARE	-Distinct part NF	All	Statewide	*
	-Freestanding NF	1-59	Los Angeles Co.	Median
		1-59	Bay Area**	Median
		1-59	All Other Counties	Median
		60+	Los Angeles Co.	Median
		60+	Bay Area**	Median
		60+	All Other Counties	Median
<hr/>				
SUBACUTE: VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	*
NON-VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	*
<hr/>				
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
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TRANSITIONAL INPATIENT CARE: REHABILITATIVE	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
MEDICAL	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
<hr/>				
NF LEVEL A	-All	1-99	Los Angeles Co.	Median
		1-99	Bay Area**	Median
		1-99	All Other Counties	Median
		100+	Statewide	***
<hr/>				
ICF/DD	-All	1-59	Statewide	65th percentile
		60+	Statewide	65th percentile
<hr/>				
ICF/DD-Hs and Ns	-All	4-6	Statewide	65th percentile
		7-15	Statewide	65th percentile
<hr/>				
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 As.