*DHCS Logo
David Maxwell-Jolly
Director

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

*Seal of California
Arnold Schwarzenegger
Governor

ACTION: Notice of Emergency Rulemaking Title 22, California Code of Regulations
SUBJECT: Long-Term Care Reimbursement, DHCS-03-030E

The Department of Health Care Services (Department) has adopted the regulations described in this notice on an emergency basis and they are now in effect.

PUBLIC PROCEEDINGS: Notice is hereby given that the Department will conduct written public proceedings, during which time any interested person or such person's duly authorized representative may present statements, arguments or contentions (all of which are hereinafter referred to as comments) relevant to the action described in this notice.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW:

Welfare and Institutions Code Section 14105 requires the Department to adopt regulations establishing reimbursement rates for Medi-Cal providers of health care services and mandates for the emergency adoption of regulations for these changes in response to legislative budgeting decisions.

This emergency regulatory action amends the California Code of Regulations (CCR), Title 22 to reflect reimbursement rates established by the Department for specific types of facilities providing long-term care services to Medi-Cal beneficiaries. There are two time periods affecting the CCR sections established in the table below that are revealed through this regulatory action. The first time period being July 1, 2003 through July 31, 2003, which reflects the standard reimbursement rate for that period in addition to the Quality Assurance Fee (QAF), as described below. The second time period is the rate year August 1, 2003 through July 31, 2004. In the 2003-04 Budget Act (Chapter 157, Statutes of 2003), Items 4260-101-0001 and 4260-101-0890, the Legislature appropriated funding to pay these rates. These reimbursement rates are for services provided on or after August 1, 2003 and include the QAF, as described below.

This regulatory action establishes that reimbursement rates, as described above, include the QAF, pursuant to provisions under Health and Safety Code, Sections 1324 through 1324.14. These provisions require the Department to impose a QAF of six percent of the entire gross receipts for each Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H), and Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N), effective July 1, 2003.

The Title 22, CCR sections that are affected through this regulatory action, the service and the weighted average percentage change are specified in the table below.

Section
51510 (e)
Service
Nursing Facility Level A Services
Weighted Average Percentage Change
1.47

Section
51510.1(d) & (e)
Service
Intermediate Care Services for the
Developmentally Disabled
Weighted Average Percentage Change
2.38

Section
51510.2(a)
Service
Intermediate Care Services for the Developmentally Disabled-Habilitative
Weighted Average Percentage Change
0.00

Section
51510.3(a)
Service
Intermediate Care Services for the Developmentally Disabled-Nursing
Weighted Average Percentage Change
0.00

Section
51511(a)
Service
Nursing Facility Level B Services 2003-04
Weighted Average Percentage Change
3.92

Section
51511.5(a), (e) (f) & (g)
Service
Nursing Facility Services – Subacute Care Reimbursement
Weighted Average Percentage Change
0.82

Section
51511.6(a), (b) & (c)
Service
Nursing Facility Services – Pediatric Subacute Care Reimbursement
Weighted Average Percentage Change
2.00

Section
51535(d)
Service
Leave of Absence
Weighted Average Percentage Change
2.02

Section
51535.1(d)
Service
Bed Hold for Acute Hospitalization
Weighted Average Percentage Change
2.02

Section
51544(h)
Service
Hospice Care
Weighted Average Percentage Change
N/A

Section
54501(b)
Service
Adult Day Health Care Services
Weighted Average Percentage Change
1.47

The percentages listed above cannot be used to determine the rate for each facility category from the prior year. The percentage changes shown above are averages of all

facility categories in each regulation section, weighted by patient days for those categories.

In addition to the reimbursement rates as specified above this regulatory action will also accomplish the following:

- Make non-substantial grammatical, typographical, organization, cross reference, and capitalization amendments where applicable throughout the regulations.
- Under Section 51510(e) specify rates for freestanding Level A nursing facilities.
- Under Sections 51511(a)(2)(C) and 51511.5(f)(2) state the audit disallowance factor to reflect data for the fiscal year 2003-04 rate setting period.
- Under Sections 51511 and 51511.5 revise dates to reflect the fiscal year 2003-04 rate setting period.
- Under Section 51544(h) set forth that payment for hospice care services shall be 95 percent of the facility's Medi-Cal per diem rate where the patient resides.

AUTHORITY:
Sections 20, 1267.7 and 1275.3 Health and Safety Code; and Sections 10725, 14105, 14108, 14108.1, 14108.2, 14109.5, 14110.6, 14110.7, 14124.5, 14125.5, 14126.023 and 14570, Welfare and Institutions Code.

REFERENCE:
Sections 14053, 14087.3, 14105, 14105.47, 14105.981,14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7, 14123, 14132.22, 14132.25 and 14571, Welfare and Institutions Code; Sections 1250, 1267.7, 1275.3, 1324, 1324.2, 1324.4, 1324.6, 1324.8, 1324.10, 1324.12 and 1324.14 Health and Safety Code; Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890; Sections 447.15 and 483.1, et seq., Title 42, Code of Federal Regulations; 42 United States Code Section 1396(a)(13)(B) [Section 1902(a)(13)(B) of the Federal Social Security Act]; and the Settlement Agreement in California Association for Adult Day Services v. Department of Health Services, January 12, 1994, San Francisco County Superior Court (Case Number 944047).

COMMENTS: Any written comments pertaining to these regulations, regardless of the method of transmittal, must be received by the Office of Regulations by 5 p.m. on September 3, 2010, which is hereby designated as the close of the written comment period. Comments received after this date will not be considered timely. Persons wishing to use the California Relay Service may do so at no cost. The telephone numbers for accessing this service are: 1-800-735-2929, if you have a TDD; or 1-800-735-2922, if you do not have a TDD. Written comments may be submitted as follows:

1. By mail or hand-delivered to the Office of Regulations, Department of Health Care Services, MS 0015, 1501 Capitol Avenue, P.O. Box 997413, Sacramento, CA 95899-7413; or
2. By fax transmission: (916) 440-5748; or

3. By email to regulations@dhcs.ca.gov (it is requested that email transmissions of comments, particularly those with attachments, contain the regulation package identifier "DHCS-03-030E" in the subject line to facilitate timely identification and review of the comment).

All comments, including email or fax transmissions, should include the author's name and U.S. Postal Service mailing address in order for the Department to provide copies of any notices for proposed changes to the regulation text on which additional comments may be solicited.

INQUIRIES: Inquiries regarding the substance of the emergency regulations described in this notice may be directed to Sandy Yien of the Rate Development Branch, at (916) 552-9636.

All other inquiries concerning the action described in this notice may be directed to Ben Carranco of the Office of Regulations, at (916) 440-7766, or to the designated backup contact person, Lynette Cordell, at (916) 650-6827.

CONTACTS: In any inquiries or written comments, please identify the action by using the Department regulation package identifier, DHCS-03-030E.

AVAILABILITY OF STATEMENT OF REASONS AND TEXT OF REGULATIONS: The Department has prepared and has available for public review an initial statement of reasons for the emergency regulations, all the information upon which the emergency regulations are based, and the text of the emergency regulations. The Office of Regulations, at the address noted above, will be the location of public records, including reports, documentation, and other material related to the emergency regulations (rulemaking file). In addition, a copy of the final statement of reasons (when prepared) will be available upon request from the Office of Regulations.

Materials regarding the action described in this notice (including this public notice, the regulation text, and the initial statement of reasons) that are available via the Internet may be accessed at www.dhcs.ca.gov by clicking on the Decisions Pending and Opportunity for Public Participation link (from the left menu), then selecting the Proposed Regulations link.

In order to request a copy of this public notice, the regulation text, and the initial statement of reasons be mailed to you, please call (916) 440-7695 (or California Relay at 711/1-800-735-2929), or email regulations@dhcs.ca.gov, or write to the Office of Regulations at the address noted above. Upon specific request, these documents will be made available in Braille, large print, and audiocassette or computer disk.

AVAILABILITY OF CHANGED OR MODIFIED TEXT: The full text of any regulation which is changed or modified from the express terms of the emergency action will be

made available by the Department's Office of Regulations at least 15 days prior to the date on which the Department adopts, amends, or repeals the resulting regulation.

FISCAL IMPACT ESTIMATE:

A. Fiscal Effect on Local Government: None

B. Fiscal Effect on State Government: Additional Cost of $51,259,000 in fiscal year 2003-04 and $61,775,000 annually. These costs were included in the May 2004 Estimate and are now included in the ongoing Medi-Cal base expenditures.

C. Fiscal Effect on Federal Funding of State Programs: Additional Cost of $51,259,000 in fiscal year 2003-04 and $61,775,000 annually. These costs were included in the May 2004 Estimate and are now included in the ongoing Medi-Cal base expenditures.

D. All cost impacts, known to the agency at the time the notice of proposed action was submitted to the Office of Administrative Law, that a representative private person or business would necessarily incur in reasonable compliance with the proposed action: The agency is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

E. Other nondiscretionary costs or savings including revenue changes imposed on State or Local Government: None

DETERMINATIONS: The Department has determined that the regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

The Department has made an initial determination that the regulations would not have a significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

The Department has determined that the regulations would not significantly affect the following:

(1) The creation or elimination of jobs within the State of California.

(2) The creation of new businesses or the elimination of existing businesses within the State of California.

(3) The expansion of businesses currently doing business within the State of California

The Department has determined that the regulations would not affect small business because the regulations do not impose any additional reporting, recordkeeping, or other compliance requirements on small businesses.

The Department has determined that the regulations will have no impact on housing costs.

ADDITIONAL STATEMENTS AND COMMENTS: In accordance with Government Code Section 11346.5(a)(13) the Department must determine that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed action.

No public hearing has been scheduled; however any interested person or his or her duly authorized representative may request in writing, no later than 15 days prior to the close of the written comment period, a public hearing pursuant to Government Code Section 11346.8, The Department shall consider all comments received regarding the proposal equally, whether submitted in writing or through oral testimony at a public hearing.

For individuals with disabilities, the Department will provide assistive services such as – sign-language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of public hearing materials into Braille, large print, audiocassette, or computer disk. To request such services or copies in an alternate format, please call or write: Susan Pierson, Office of Regulations, MS 0015, P.0. Box 997413, Sacramento, CA 95899-7413, voice (916) 440-7695; and/or California Relay 711/1-800-735-2929. Note: The range of assistive services available may be limited if requests are received less than ten business days prior to a public hearing.

DHCS-03-030E
Dated: May 11, 2010

DEPARTMENT OF HEALTH CARE SERVICES

*Signed
David Maxwell-Jolly
Director

FINDING OF EMERGENCY

This regulatory action adopts rates, for facilities providing long-term care, that the California Department of Health Care Services (Department) established for the 2003-04 rate year, August 1, 2003 through July 31, 2004 pursuant to funding in the 2003-04 Budget Act, Items 4260-101-0001 and 4260-101-0890 (Ch. 157, Stats. 2003, para. 2.00, pp. 282, 284, 286, 294). These regulations must be adopted as an emergency and will provide for the official regulatory publication of these rates for which facilities have received funding.

Welfare and Institutions Code Section 14105, subdivision (a), provides as follows:

> The director shall prescribe the policies to be followed in the administration of this chapter, may limit the rates of payment for health care services, and shall adopt any rules and regulations as are necessary for carrying out, but are not inconsistent with, the provisions thereof.
>
> The policies and regulations shall include rates for payment for services not rendered under a contract pursuant to Chapter 8 (commencing with Section 14200). In order to implement expeditiously the budgeting decisions of the Legislature, the director shall, to the extent permitted by federal law, adopt regulations setting rates that reflect these budgeting decisions within one month after the enactment of the Budget Act and of any other appropriation that changes the level of funding for Medi-Cal services. With the written approval of the Department of Finance, the director shall adopt the regulations as emergency regulations in accordance with the Administrative Procedures Act (Chapter 3.5 commencing with Section 11340, Part 1, Division 3, Title 2 of the Government Code). For purposes of that Act, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare.

Pursuant to Welfare and Institutions Code Section 14105, the adoption of these regulatory changes is “deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare.”

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Welfare and Institutions Code Section 14105 requires the Department to adopt regulations establishing reimbursement rates for Medi-Cal providers of health care services and mandates for the emergency adoption of regulations for these changes in response to legislative budgeting decisions.

This emergency regulatory action amends the California Code of Regulations (CCR), Title 22 to reflect reimbursement rates established by the Department for specific types of facilities providing long-term care services to Medi-Cal beneficiaries. There are two time periods affecting the CCR sections established in the table below that are revealed through this regulatory action. The first time period being July 1, 2003 through July 31,

2003, which reflects the standard reimbursement rate for that period in addition to the Quality Assurance Fee (QAF), as described below. The second time period is the rate year August 1, 2003 through July 31, 2004. In the 2003-04 Budget Act (Chapter 157, Statutes of 2003), Items 4260-101-0001 and 4260-101-0890, the Legislature appropriated funding to pay these rates. These reimbursement rates are for services provided on or after August 1, 2003 and include the QAF, as described below.

This regulatory action establishes that reimbursement rates, as described above, include the QAF, pursuant to provisions under Health and Safety Code, Sections 1324 through 1324.14. These provisions require the Department to impose a QAF of six percent of the entire gross receipts for each Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H), and Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N), effective July 1, 2003.

The Title 22, CCR sections that are affected through this regulatory action, the service and the weighted average percentage change are specified in the table below.

Section
51510 (e)
Service
Nursing Facility Level A Services
Weighted Average Percentage Change
1.47

Section
51510.1(d) & (e)
Service
Intermediate Care Services for the
Developmentally Disabled
Weighted Average Percentage Change
2.38

Section
51510.2(a)
Service
Intermediate Care Services for the Developmentally Disabled-Habilitative
Weighted Average Percentage Change
0.00

Section
51510.3(a)
Service
Intermediate Care Services for the Developmentally Disabled-Nursing
Weighted Average Percentage Change
0.00

Section
51511(a)
Service
Nursing Facility Level B Services
2003-04
Weighted Average Percentage Change
3.92

Section
51511.5(a), (e) (f) & (g)
Service
Nursing Facility Services – Subacute Care Reimbursement
Weighted Average Percentage Change
0.82

Section
51511.6(a), (b) & (c)
Service
Nursing Facility Services – Pediatric Subacute Care Reimbursement
Weighted Average Percentage Change
2.00

Section
51535(d)
Service
Leave of Absence
Weighted Average Percentage Change
2.02

Section
51535.1(d)
Service
Bed Hold for Acute Hospitalization
Weighted Average Percentage Change
2.02

Section
51544(h)
Service
Hospice Care
Weighted Average Percentage Change
N/A

Section
54501(b)
Service
Adult Day Health Care Services

Weighted Average Percentage Change
1.47

The percentages listed above cannot be used to determine the rate for each facility category from the prior year. The percentage changes shown above are averages of all facility categories in each regulation section, weighted by patient days for those categories.

In addition to the reimbursement rates as specified above this regulatory action will also accomplish the following:

- Make non-substantial grammatical, typographical, organization, cross reference, and capitalization amendments where applicable throughout the regulations.
- Under Section 51510(e) specify rates for freestanding Level A nursing facilities.
- Under Sections 51511(a)(2)(C) and 51511.5(f)(2) state the audit disallowance factor to reflect data for the fiscal year 2003-04 rate setting period.
- Under Sections 51511 and 51511.5 revise dates to reflect the fiscal year 2003-04 rate setting period.
- Under Section 51544(h) set forth that payment for hospice care services shall be 95 percent of the facility's Medi-Cal per diem rate where the patient resides.

AUTHORITY:
Sections 20, 1267.7 and 1275.3 Health and Safety Code; and Sections 10725, 14105, 14108, 14108.1, 14108.2, 14109.5, 14110.6, 14110.7, 14124.5, 14125.5, 14126.023 and 14570, Welfare and Institutions Code.

REFERENCE:
Sections 14053, 14087.3, 14105, 14105.47, 14105.981,14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7, 14123, 14132.22, 14132.25 and 14571, Welfare and Institutions Code; Sections 1250, 1267.7, 1275.3, 1324, 1324.2, 1324.4, 1324.6, 1324.8, 1324.10, 1324.12 and 1324.14 Health and Safety Code; Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890; Sections 447.15 and 483.1, et seq., Title 42, Code of Federal Regulations; 42 United States Code Section 1396(a)(13)(B) [Section 1902(a)(13)(B) of the Federal Social Security Act]; and the Settlement Agreement in California Association for Adult Day Services v. Department of Health Services, January 12, 1994, San Francisco County Superior Court (Case Number 944047).

FISCAL IMPACT ESTIMATE:

A. Fiscal Effect on Local Government: None

B. Fiscal Effect on State Government: Additional Cost of $51,259,000 in fiscal year 2003-04 and $61,775,000 annually. These costs were included in the May 2004 Estimate and are now included in the ongoing Medi-Cal base expenditures.

C. Fiscal Effect on Federal Funding of State Programs: Additional Cost of $51,259,000 in fiscal year 2003-04 and $61,775,000 annually. These costs were

included in the May 2004 Estimate and are now included in the ongoing Medi-Cal base expenditures.

D. All cost impacts, known to the agency at the time the notice of proposed action was submitted to the Office of Administrative Law, that a representative private person or business would necessarily incur in reasonable compliance with the proposed action: The agency is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

E. Other nondiscretionary costs or savings including revenue changes imposed on State or Local Government: None

DETERMINATIONS:

The Department has determined that the regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

The Department has made an initial determination that the regulations would not have a significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

The Department has determined that the regulations would not significantly affect the following:

(1) The creation or elimination of jobs within the State of California.

(2) The creation of new businesses or the elimination of existing businesses within the State of California.

(3) The expansion of businesses currently doing business within the State of California.

The Department has determined that the regulations would not affect small business because the regulations do not impose any additional reporting, recordkeeping, or other compliance requirements on small businesses.

The Department has determined that the regulations will have no impact on housing costs.

INITIAL STATEMENT OF REASONS

Welfare and Institutions (W&I) Code Section 14105 requires the Department of Health Care Services (Department) to adopt regulations establishing reimbursement rates for Medi-Cal providers of health care services and mandates for the emergency adoption of regulations for these changes in response to legislative budgeting decisions.

This emergency regulatory action amends the California Code of Regulations (CCR), Title 22 to reflect reimbursement rates established by the Department for specific types of facilities providing long-term care services to Medi-Cal beneficiaries. There are two time periods affecting the CCR sections established in the table that are revealed through this regulatory action. The first time period being July 1, 2003 through July 31, 2003, which reflects the standard reimbursement rate for that period in addition to the Quality Assurance Fee (QAF), as described below. The second time period is the rate year August 1, 2003 through July 31, 2004. In the 2003-04 Budget Act (Chapter 157, Statutes of 2003), Items 4260-101-0001 and 4260-101-0890, the Legislature appropriated funding to pay these rates. These reimbursement rates are for services provided on or after August 1, 2003 and include the QAF, as described below.

This regulatory action establishes that reimbursement rates, as described above, include the QAF, pursuant to provisions under Health and Safety (H&S) Code, Sections 1324 through 1324.14. These provisions require the Department to impose a QAF of six percent of the entire gross receipts for each Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H), and Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N), effective July 1, 2003.

The Title 22, CCR sections that are affected through this regulatory action, the service and the weighted average percentage change are specified in the table below.

<u>Section</u>
51510 (e)
<u>Service</u>
Nursing Facility Level A Services
<u>Weighted Average Percentage Change</u>
1.47

<u>Section</u>
51510.1(d) & (e)
<u>Service</u>
Intermediate Care Services for the Developmentally Disabled
<u>Weighted Average Percentage Change</u>
2.38

<u>Section</u>
51510.2(a)

Service
Intermediate Care Services for the Developmentally Disabled-Habilitative
Weighted Average Percentage Change
0.00

Section
51510.3(a)
Service
Intermediate Care Services for the Developmentally Disabled-Nursing
Weighted Average Percentage Change
0.00

Section
51511(a)
Service
Nursing Facility Level B Services
2003-04
Weighted Average Percentage Change
3.92

Section
51511.5(a), (e) (f) & (g)
Service
Nursing Facility Services – Subacute Care Reimbursement
Weighted Average Percentage Change
0.82

Section
51511.6(a), (b) & (c)
Service
Nursing Facility Services – Pediatric Subacute Care Reimbursement
Weighted Average Percentage Change
2.00

Section
51535(d)
Service
Leave of Absence
Weighted Average Percentage Change
2.02

Section
51535.1(d)
Service
Bed Hold for Acute Hospitalization
Weighted Average Percentage Change

2.02

Section
51544(h)
Service
Hospice Care
Weighted Average Percentage Change
N/A

Section
54501(b)
Service
Adult Day Health Care Services
Weighted Average Percentage Change
1.47

The percentages listed above cannot be used to determine the rate for each facility category from the prior year. The percentage changes shown above are averages of all facility categories in each regulation section, weighted by patient days for those categories.

Changes to the following sections of CCR, Title 22, are as follows:

Section
51510(e)(1)
Service
Nursing Facility Level A Services
Description
Amends rates to reflect updated facility cost data. Deletes the two categories based on number of beds or bed size and establishes one rate for all facilities irrespective of the number of beds.

Section
51510(e)(2)
Service
Nursing Facility Level A Services
Description
Adopts a new paragraph (2) that establishes rates based on peer groupings by geographical location and sets a specific rate for facilities with 100 or more beds.

Section
51510(e)(3)
Service
Nursing Facility Level A Services
Description
Moves the content of paragraph
(2) to paragraph (3) and amends the language for clarity and parallel construction.

Section
51510(e)(4)
Service
Nursing Facility Level A Services
Description
Moves the content of paragraph (3) to paragraph (4) and amends the language for clarity and parallel construction.

Section
51510.1(d)
Service
Intermediate Care Services for the Developmentally Disabled
Description
Amends rates to reflect updated facility cost data and the QAF. Adds reference to H&S Code Section 1324.2 for the QAF program, implemented 7/1/03. The amended rates effective 7/1/03 reflect rates initially established in 8/1/02 plus the QAF. The 8/1/03 rates reflect the updated facility costs plus the QAF. This subsection also includes non-substantial language changes for clarity and sentence structure and a non-substantial capitalization change under paragraph (1).

Section
51510.1(e)
Service
Intermediate Care Services for the Developmentally Disabled
Description
Removes existing language because it is no longer relevant to Section 51510.1 because the Department is no longer involved in determining the cost-based reimbursement for these facilities. Adopts new language to clarify that the rate year established under this section is August 1st through July 31st per the 2003-04 Budget Act.

Section
51510.2(a)
Service
Intermediate Care Services for the Developmentally Disabled- Habilitative
Description
Amends rates to reflect updated facility cost data and the QAF. Adds reference to H&S Code Section 1324.2 for the QAF program, implemented 7/1/03. The amended rates effective 7/1/03 reflect rates initially established in 8/1/02 plus the QAF. The 8/1/03 rates reflect the updated facility costs plus the QAF.

Section
51510.3(a)
Service
Intermediate Care Facilities for the Developmentally Disabled – Nursing
Description

Amends rates to reflect updated facility cost data and the QAF. Adds reference to H&S Code Section 1324.2 for the QAF program, implemented 7/1/03. The amended rates effective 7/1/03 reflect rates initially established in 8/1/02 plus the QAF. The 8/1/03 rates reflect the updated facility costs plus the QAF.

Section
51511(a)(1)
Service
Nursing Facility Level B Services
Description
Amends rates for both bed size categories to reflect updated facility cost data and updates the dates to reflect the fiscal year 2003-04 rate setting period.

Section
51511(a)(2)
Service
Nursing Facility Level B Services
Description
Amends the rates for nursing facilities that are distinct parts of acute care hospitals. Also amends dates and the audit disallowance factor to reflect data used for the fiscal year 2003-04 rate setting. Includes a non- substantial change under paragraph (F) adding a missing “s”.

Section
51511(a)(4)
Service
Nursing Facility Level B Services
Description
Amends designated swing bed facilities rates.

Section
51511(a)(6)
Service
Nursing Facility Level B Services
Description
Includes a non-substantial change to correct an existing inaccurate cross reference.

Section
51511.5(a)
Service
Nursing Facility Services- Subacute Care Reimbursement
Description
Updates the dates to reflect the fiscal year 2003-04 rate setting period. Conforms the regulatory language to the approved Medicaid State Plan Attachment 4.19-D. Amends the rates to reflect updated facility cost data.

Section

51511.5(e)
& (f)
Service
Nursing Facility Services – Subacute Care Reimbursement
Description
Updates the dates to reflect the fiscal year 2003-04 rate setting period and amends the audit disallowance factor. Includes a non-substantial change to spell out the acronym "DP/NF" for clarity.

Section
51511.5(g)
Service
Nursing Facility Services – Subacute Care Reimbursement
Description
Specifies a non-substantial change to correct an existing inaccurate cross reference.

Section
51511.6(a),(b), & (c)
Service
Nursing Facility Services – Pediatric Subacute Care Reimbursement
Description
Amends rates based on a model which estimates expected costs. (Refer to last paragraph under heading below: Annual Long-Term Care Reimbursement Methodology)

Section
51535(d)
Service
Leave of Absence
Description
Amends the rate based on the Consumer Price Index (CPI) applicable for the 2003-04 rate period.

Section
51535.1(d)
Service
Bed Hold for Acute Hospitalization
Description
Amends the rate based on the CPI applicable for the 2003-04 rate period.

Section
51544(h)
Service
Hospice Care
Description
Implements the Centers for Medicare
& Medicaid Services (CMS) allowable reimbursement rate for hospice care and removes existing language that is no longer accurate.

Section
54501(b)
Service
Adult Day Health Care Services
Description
Amends rates to reflect updated facility cost data.
(Report No. 01-03-02)

EXPLANATION OF CHANGES AND DATES

1. Reimbursement Rates

(a) The reimbursement rates are updated to reflect data from each facility's annual or fiscal period closing cost report (except for Pediatric Subacute Care facilities where updated rates are based on a model). Reported costs are adjusted based on audits of reported costs performed by the Department's Audits and Investigations Program, Financial Audits Branch. These rates represent the maximum amount paid for services provided on or after August 1, 2003.

(b) In Sections 51510(e)(1) & (2)

Effective August 2, 2003, Level A Free Standing Nursing Facility's, regardless of the number of beds, would have rates set depending on the facility's geographical location using the methodology currently applicable to Los Angeles, Bay Area or all other counties. Facilities with licensed bed capacities with 100+ bedsize who received a rate of $89.54 effective August 1, 2002, will continue to receive a reimbursement of at least $89.54 until such time their prospective county rate exceeds the $89.54 reimbursement rate. When the prospective county rate exceeds the $89.54 reimbursement rate, facilities with licensed bed capacities with 100+ bedsize will receive the higher rate.

(c) In Section 51544(h)

Initially the Hospice room and board reimbursement rate was set at 95 percent of the weighted rate for nursing facilities Level A and nursing facilities Level B. The rate should have been set at the CMS reimbursement rate of 95 percent of the facility's Medi-Cal per diem rate where the individual resides. However, due to the Department's fiscal intermediary, Electronic Data System (EDS), not being able to accommodate the 95 percent Medi-Cal per diem, the Department negotiated with Hospice providers to reimburse at 95 percent of the weighted rate. EDS has since updated their systems to accommodate billing at 95 percent of the facility's Medi-Cal per diem rate where the Hospice patient resides. The rates listed in Subsection (h)(1) are no longer applicable and therefore removed and the applicable rate in Subsection (h)(2) has been moved directly under (h) for organizational clarity.

2. Audit Disallowance Factor and Dates

In Sections 51511(a)(2)(C) and 51511.5(f)(2), the audit disallowance factor and dates are updated to reflect the fiscal year 2003-04 rate setting period. The audit disallowance factor is based on audits of a random sample of facilities, reflects costs that are found not to be allowable costs under the Medi-Cal program, and is applied to all facilities in that regulation section.

ANNUAL LONG-TERM CARE REIMBURSEMENT METHODOLOGY

Welfare and Institutions Code Section 14126.25 requires that the Department establish reimbursement rates for long-term care facilities by August 1st of each year. These rates are established on the basis of cost data submitted by facilities as defined under the Department's California State Plan.

The Department's reimbursement methodology for long-term care facilities provides for a prospective flat-rate system with long-term care facilities divided into peer groups by licensure status, level of care, geographic area, and/or bedsize. Rates for each category (except Pediatric Subacute, as explained below) are determined based on data obtained from each facility's annual or fiscal period closing cost report. All reported costs are adjusted based on audits of reported costs performed by the Department's Audits and Investigations Program, Financial Audits Branch. For ICF/DD, Freestanding Nursing Facilities Level A, Distinct Part Nursing Facilities and Subacute Facilities, each facility is audited. For Freestanding Nursing Facilities Level B, ICF/DD-H and ICF/DD-N, a sample from each peer group is audited and the combined results of these audits, by peer group, are used to calculate an audit disallowance factor. The audit disallowance factor is applied to each facility in the peer group.

Each annual long-term care rate is determined separately based on costs (except for the Pediatric Subacute rate, which uses a model, as described below). The rate for 6 prior years is not used as the basis of the rate for the present year. Most facilities' cost reports are filed with the Office of Statewide Health, Planning and Development (OSHPD), and are made available to the Department for the annual rate setting process. The cost report information that the Department uses for the annual rate setting process is approximately two, to two and one-half years old. For this reason, the Department's projects each facility's costs for the upcoming rate year by utilizing this cost report data through data base analysis, review, and research on cost components and new program requirement costs.

Pediatric Subacute reimbursement is based on a model. The model projecting costs for Pediatric Subacute services was developed because of the limited cost data available for such services. The model is an estimate of the expected costs for this level of care and is updated each year based on selected update factors used for other levels of care.

COST COMPONENTS USED TO PROJECT COSTS

The adjusted long-term care costs are segregated into four categories: (1) fixed costs, which is comprised of interest, depreciation, leasehold improvements, and rent; (2) property tax; (3) labor expenses; and (4) all other costs. The rate methodology includes the development and use of established economic indicators to update costs from the midpoint of a facility's fiscal reporting period to the midpoint of the Medi-Cal rate year.

Under the federally approved State Plan rate setting methodology, rates for each rate year are based on projected costs for providers. Those projected costs are based on cost reports submitted by providers for a period approximately two years prior to the rate year. Various adjustments are applied to the reported costs, including inflation adjustments, as part of the process of determining each provider's projected costs for the rate year.

ADD-ONS

Additionally, the State Plan provides that adjustments or add-ons to projected costs will be made to reflect certain increases in provider costs that occurred after the cost reporting period. Under the State Plan, there are mandatory cost add-ons and discretionary cost add-ons.

The State Plan provides that when federal or state statutes or regulations impose new requirements on facilities after the cost reporting period, which add additional provider costs that would have not been reflected in provider cost reports used to establish the rates, projected costs must be increased by an appropriate add-on to reflect these additional costs. These cost add-ons, based on changes mandated by statute or regulation, are mandatory cost add-ons under the State Plan.

The State Plan also provides that the Department has the discretion to provide cost add-ons to projected costs to reflect "extraordinary costs" experienced by providers that would not have been reflected in the fiscal periods for the cost reports used to establish rates. When the Department was establishing the rates for the 2003-04 rate year, no add-ons were given.

The Department also concluded that the rates it established for the 2002-03 rate year were sufficient to assure that there would be enough long-term care providers to provide adequate access to quality long-term care services for Medi-Cal beneficiaries in need of such services. Thus, providing additional cost add-ons in order to further increase rates was unnecessary.

PROVIDER INPUT

The Department accepts input from industry representatives and organizations as part of the rate setting process. The California Association of Health Facilities, the California Hospital Association (previously known as California Healthcare Association), the Developmental Services Network, and Beverly Enterprises are among the groups that participated in discussions, or provided input to the Department's Medi-Cal Benefits, Waiver Analysis and Rates Division staff during the Department's rate setting process.

The public notice of rate setting changes was published in the California Regulatory Notice Register on July 26, 2002 (Register 2002, Volume Number 30-Z).

SUPPORTING DOCUMENTATION

Listed below are the documents that the Department relied upon for this emergency action, including the studies performed during the annual rate setting process:

1) Report No. 01-03-01 (Study To Develop Labor Index For Long-Term Care Facilities).

2) Report No. 01-03-02 (Reimbursement Study for Long-Term Care Services).

3) 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 (State Plan) Attachment 4.19-D TN 05-005 Approval Date September 9, 2005.

REFERENCE

1) Consumer Price Index: http://www.dof.ca.gov/HTML/FSDATA/LatestEconData/FSPrice.htm

The regulations do not overlap or duplicate other existing state regulations.

STATEMENTS OF DETERMINATION

A. ALTERNATIVES CONSIDERED

The Department has determined that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which this action is proposed, or would be as effective and less burdensome to affected private persons than the emergency action.

B. LOCAL MANDATE DETERMINATION

The Department has determined that the emergency regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

C. ECONOMIC IMPACT STATEMENT

The Department has made an initial determination that the emergency regulations would not have a significant statewide adverse economic impact directly affecting businesses including the ability of California businesses to compete with businesses in other states.

The Department has determined that the emergency regulations would not significantly affect the following:

(1) The creation or elimination of jobs within the State of California.

(2) The creation of new businesses or the elimination of existing businesses within the State of California.

(3) The expansion of businesses currently doing business within the State of California.

This determination is made on the basis that the regulations reflect rate changes based upon reported costs that are prospectively updated for economic indicators and adjusted for audit results.

D. EFFECT ON SMALL BUSINESSES

The Department has determined that the emergency regulations would not affect small businesses. The regulations do not impose any additional reporting, recordkeeping, or other compliance requirements on small businesses.

E. HOUSING COSTS DETERMINATION

The Department has made the determination that the emergency regulations would have no impact on housing costs.

METHOD OF INDICATING CHANGES

This Accessible PDF version of the approved emergency regulation text includes the phrase [begin underline] at the beginning of each addition, [end underline] at the end of each addition, [begin strikeout] at the beginning of each deletion, and [end strikeout] at the end of each deletion.

A standard PDF version of this approved emergency regulation text is also available on the Department's Office of Regulations Internet site.

(1) Amend Section 51510 to read as follows:

§ 51510. Nursing Facility Level A Services.

(a) – (d) No change

(e) Payment to nursing facilities or public institutions providing Level A services in accordance with Section 51120 shall be as follows:

(1) [begin strikeout] ~~For facilities with licensed bed capacities and located by county as follows:~~ [end strikeout] [begin underline] <u>For facilities in the following counties the base rate is:</u> [end underline]

[begin strikeout] ~~Bedsize~~ [end strikeout] [begin strikeout] ~~1-99~~ [end strikeout]

Los Angeles County $80.62

[begin strikeout] ~~Bedsize~~ [end strikeout] [begin strikeout] ~~100+~~ [end strikeout]

Los Angeles County [begin strikeout] ~~$89.54~~ [end strikeout]

[begin strikeout] ~~Bedsize~~ [end strikeout] [begin strikeout] ~~1-99~~ [end strikeout]

Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara & Sonoma Counties $80.62

[begin strikeout] ~~Bedsize~~ [end strikeout] [begin strikeout] ~~100+~~ [end strikeout]

Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara & Sonoma Counties [begin strikeout] ~~$89.54~~ [end strikeout]

[begin strikeout] ~~Bedsize~~ [end strikeout] [begin strikeout] ~~1-99~~ [end strikeout]

All other Counties $67.94

[begin strikeout] ~~Bedsize~~ [end strikeout] [begin strikeout] ~~100+~~ [end strikeout]

All other Counties [begin strikeout] ~~$85.54~~ [end strikeout]

(2) [begin strikeout] ~~Reduced for leave of absence provided pursuant to Section 51535.~~ [end strikeout] [begin underline] For facilities with licensed bed capacities of 100 beds or more, effective August 2, 2003, each facility shall receive a rate of $89.54 until the prospective county rate for their geographic location based on the categories listed above exceeds that amount. At that time, those facilities shall receive the rate for all facilities within that geographic location. [end underline]

(3) [begin strikeout] ~~Reduced for bed hold provided pursuant to Section 51535.1.~~ [end strikeout] [begin underline] For a leave of absence, the base rate shall be reduced pursuant to Section 51535.

(4) For bed holds, the base rate shall be reduced pursuant to Section 51535.1. [end underline]

(f) – (j) No Change

NOTE: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, 14108, 14108.1, 14110.6, 14110.7, 14124.5 and [begin strikeout] ~~14126.23~~ [end strikeout] [begin underline] 14126.023 [end underline], Welfare and Institutions Code. Reference: Sections [begin strikeout] ~~14105.47~~ [end strikeout], 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7 and [begin strikeout] ~~14132~~ [end strikeout] [begin underline] 14123 [end underline], Welfare and Institutions Code; and Statutes of [begin strikeout] ~~2002~~ [end strikeout] [begin underline] 2003 [end underline], Chapter [begin strikeout] ~~379~~ [end strikeout] [begin underline] 157 [end underline], Items 4260-101-0001 and 4260-101-0890.

(2) Amend Section 51510.1 to read as follows:

§ 51510.1. Intermediate Care Services for the Developmentally Disabled.

(a) – (c) No change

(d) Skilled nursing facilities and intermediate care facilities with the licensed bed capacities shown below meeting the standards and criteria established for intermediate care facility services for the developmentally disabled, as defined in Sections 76301 through 76413, Article 3, Chapter 8, Division 5, Title 22, California Code of Regulations, shall be entitled to payment [begin strikeout] ~~for services as indicated below~~ [end strikeout] [begin underline] according to the following daily rates. Payment for service includes the Quality Assurance Fee pursuant to Health and Safety Code Section 1324.2 [end underline].

Total Licensed Beds	
[begin underline] **7/1/03 – 7/31/03** [end underline]	
1-59	[begin strikeout] ~~$128.86~~ [end strikeout]
	[begin underline] $141.19 [end underline]
60+	[begin strikeout] ~~$110.15~~ [end strikeout]
	[begin underline] $120.69 [end underline]
60+ w/Distinct Part	[begin strikeout] ~~$110.15~~ [end strikeout]
	[begin underline] $120.69 [end underline]
	8/1/03
1-59	[begin underline] $143.95 [end underline]
60+	[begin underline] $123.87 [end underline]
60+ w/Distinct Part	[begin underline] $123.87 [end underline]

(1) Reduced for leave of absence for all patients receiving intermediate care facility services for the developmentally disabled in accordance with Section 51535.

(2) Reduced for bed hold for acute hospitalization for all patients receiving intermediate care facility services for the developmentally disabled in accordance with Section 51535.1.

(e) [begin strikeout] ~~Effective October 1, 1990, state operated facilities shall be entitled to payment for services at actual allowable cost.~~ [end strikeout] [begin underline] For purposes of this section, the rate year is August 1st through July 31st. [end underline]

NOTE: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, 14108, 14110.6, 14110.7, 14124.5 and [begin strikeout] ~~14126.23~~ [end strikeout] [begin underline] 14126.023 [end underline], Welfare and Institutions Code. Reference: Sections 14087.3, [begin strikeout] ~~14105.47,~~ [end strikeout] 14108, 14109.5, 14110.4, 14110.6, 14110.7 and [begin strikeout] ~~14132~~ [end strikeout] [begin underline] 14123 [end underline], Welfare and Institutions Code; Section[begin underline]s[end underline] 1250, [begin underline] 1324, 1324.2, 1324.4, 1324.8, 1324.10 and 1324.12, [end underline] Health and Safety Code; and Statutes of [begin strikeout]~~2002~~[end strikeout][begin underline]2003[end underline], Chapter [begin strikeout]~~379~~[end strikeout][begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890.

(3) Amend Section 51510.2 to read as follows:

§ 51510.2. Intermediate Care Services for the Developmentally Disabled – Habilitative.

(a) Daily Reimbursement Rate – Intermediate care facilities meeting licensing and Medi-Cal standards and criteria for providing services to the developmentally disabled-habilitative as contained or referred to in Section 51164.1 through 51343.1, and Sections 76801 through 76962, Divisions 3 and 5 of Title 22, California Code of Regulations, shall be entitled to payment according to the following daily rates [begin strikeout]:[~~end strikeout~~][begin underline].[end underline] [begin underline] Payment for service includes the Quality Assurance Fee pursuant to Health and Safety Code Section 1324.2. [end underline]

Total Licensed Beds	
[begin underline] **7/1/03 – 7/31/03** [end underline]	
4-6	[begin strikeout] ~~$149.17~~ [end strikeout]
	[begin underline] $163.45 [end underline]
7-15	[begin strikeout] ~~$148.17~~ [end strikeout]
	[begin underline] $162.35 [end underline]
[begin underline] **8/1/03** [end underline]	
4-6	[begin underline] $163.45 [end underline]
7-15	[begin underline] $163.18 [end underline]

(a)(1) – (d) No change

NOTE: Authority cited: Sections 20 and 1267.7, Health and Safety Code; and Sections 10725, 14105, 14108, 14108.2, 14110.6, 14110.7, 14125.5 and [begin strikeout] ~~14126.23~~[end striketout][begin underline]14126.023[end underline], Welfare and Institutions Code. Reference: Sections 1250, 1267.7, [begin underline] 1324, 1324.2, 1324.4, 1324.6, 1324.8, 1324.10 and 1324.12, [end underline] Health and Safety Code; Sections 14105.47, 14108, 14108.2, 14109.5, 14110.4, 14110.6 and [begin strikeout] ~~14132~~ [end strikeout] [begin underline] 14123[end underline], Welfare and Institutions Code; and Statutes of [begin strikeout] ~~2001~~[end strikeout][begin underline]2003[end underline], Chapter [begin strikeout]~~106~~[end strikeout][begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890.

(4) Amend Section 51510.3 to read as follows:
§ 51510.3. Intermediate Care Services for the Developmentally Disabled-Nursing

(a) Daily Reimbursement Rate – Intermediate care facilities meeting licensing and Medi-Cal Standards and criteria for providing services to the developmentally disabled-nursing as contained or referred to in Sections 51164.2 through 51343.2, Division 3, and Sections 73800 through 73956, Division 5, Title 22, California Code of Regulations, shall be entitled to payment according to the following daily rates[begin strikeout]~~:~~[~~end strikeout~~][begin underline].[end underline] [begin underline] Payment for service includes the Quality Assurance Fee pursuant to Health and Safety Code Section 1324.2. [end underline]

Total Licensed Beds	
[begin underline] **7/1/03 – 7/31/03** [end underline]	
4-6	[begin strikeout]~~$182.79~~[end strikeout]
	[begin underline]$200.28[end underline]
7-15	[begin strikeout]~~$162.09~~[end strikeout]
	[begin underline]$177.60[end underline]
[begin underline] **8/1/03** [end underline]	
4-6	[begin underline] $200.28[end underline]
7-15	[begin underline]$177.60[end underline]

(a)(1) – (e) No change

Note: Authority cited: Sections 20 [begin underline] , 1267.7 [end underline] and 1275.3, Health and Safety Code; and Sections 10725, 14105, [begin underline] 14108, 14108.2, 14110.6, 14110.7 [end underline], 14125.5 and [begin strikeout] ~~14126.23~~ [end strikeout] [begin underline] 14126.023 [end underline], Welfare and Institutions Code. Reference: Sections [begin strikeout] ~~1250.1 and 1275.3~~ [end strikeout] [begin underline] 1250, 1267.7, 1324, 1324.2, 1324.4, 1324.6, 1324.8, 1324.10, 1324.12 and 1324.14 [end underline], Health and Safety Code; Sections [begin strikeout] ~~14105, 14105.47,~~ [end strikeout] 14108, [begin underline] 14108.2, 14109.5, 14110.4, 14110.6 [end underline] and [begin strikeout] ~~14132~~[end strikeout][begin underline]14123[end underline], Welfare and Institutions Code; and Statutes of [begin strikeout]~~2001~~[end strikeout] [begin underline]2003[end underline], Chapter [begin strikeout]~~106~~[end strikeout] [begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890.

(5) Amend Section 51511 to read as follows:

§ 51511. Nursing Facility Level B Services.

(a) Payment to nursing facilities, hospitals, or public institutions providing Level B services in accordance with Section 51123 shall be as set forth in this section. As used in this section, the term "nursing facility Level B services" is defined as nursing facility services provided in accordance with Section 51123. Payment shall be as follows:

(1) For facilities with licensed bed capacities and located by county, [begin underline] for the 2003-04 rate year are [end underline] as follows:

Bedsize 1-59 Los Angeles County

[begin strikeout] ~~$104.39~~ [end strikeout]

[begin underline] $107.06 [end underline]

Bedsize 60+ Los Angeles County

[begin strikeout] ~~$103.54~~ [end strikeout]

[begin underline] $107.20 [end underline]

Bedsize 1-59 Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara & Sonoma

[begin strikeout] ~~$129.96~~ [end strikeout]

[begin underline] $132.57 [end underline]

Bedsize 60+ Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara & Sonoma

[begin strikeout] ~~$131.08~~ [end strikeout]

[begin underline] $139.34 [end underline]

Bedsize 1-59 All Other Counties

[begin strikeout] ~~$113.98~~ [end strikeout]

[begin underline] $115.19 [end underline]

Bedsize 60+ All Other Counties

[begin strikeout] ~~$115.21~~ [end strikeout]

[begin underline] $119.60 [end underline]

(2) For nursing facilities that are distinct parts of acute care hospitals, if such facilities are not state operated, the per-diem reimbursement rate shall be the lesser of the facility's costs, as projected by the Department, or [begin strikeout] ~~$236.38~~ [end strikeout] [begin underline] $236.82 [end underline].

(A) For purposes of this section, the rate year is August 1, [begin strikeout] ~~2002~~[end strikeout][begin underline]2003[end underline], through July 31, [begin strikeout]~~2003~~[end strikeout][begin underline]2004[end underline].

(B) The facility's projected costs shall be based on the audit report findings of cost reports with fiscal periods ending January 1, [begin strikeout] ~~2000,~~[end strikeout][begin underline]2001,[end underline] through December 31, [begin strikeout]~~2000~~ [end strikeout][begin underline] 2001[end underline]. In the event the provider appeals the audit, pursuant to Welfare and Institutions Code Section 14171, and the provider notifies the Department by June 1, [begin strikeout]~~2002~~[end strikeout][begin underline]2003[end underline], that the audit report findings have been modified by an appeal decision or an agreement between the hospital and the Department, the facility's projected costs shall be based on the modified audit findings.

(C) If the audit of a cost report is not issued by July 1, [begin strikeout] ~~2002~~[end strikeout][begin underline]2003[end underline], the Department shall establish an interim projected reimbursement rate based on the cost report with a fiscal period ending January 1, [begin strikeout] ~~2000~~[end strikeout][begin underline]2001[end underline],

through December 31, [begin strikeout]~~2000~~[end strikeout][begin underline]2001[end underline], adjusted by an audit disallowance factor of [begin strikeout]~~.95451~~[end strikeout][begin underline]96106[end underline].

(D) The Department will use the facility's interim projected reimbursement rate in the computation of the prospective class median rate. Facilities that did not provide Nursing Facility Level B 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. In addition, facilities with Medi-Cal patient days representing less than 20 percent of their total patient days will be excluded from the median determination.

(E) If the facility has an interim reimbursement rate as specified in (C), 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, [begin strikeout]~~2002~~[end strikeout][begin underline] 2003,[end underline] 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. The Department shall notify the provider of the revised rates within 45 days of issuance of the audit report.

(F) Interest will accrue from August 1, [begin strikeout]~~2002~~[end strikeout] [begin underline]2003,[end underline] 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 referenced in Welfare and Institution[begin underline]s[end underline] Code, Section 14171) during the month the audit report is issued.

(G) If a provider appeals an audit pursuant to Welfare and Institutions Code Section 14171, and there is a 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 subsection (a)(2)(A).

(H) Payment under subsection (a)(2) shall only be made for services authorized pursuant to conditions set forth in Section 51335 for patients determined to need Level B services for other than post-surgical rehabilitation or therapy services.

(3) Reimbursement to any state-operated facility shall be based on its actual allowable costs.

(4) For facilities that are designated as swing bed facilities, the rate is [begin strikeout]~~$226.59~~[end strikeout][begin underline]$229.96[end underline].

(5) Reduced for leave of absence provided pursuant to Section 51535.

(6) Reduced for bed hold provided pursuant to Section 51535 [begin underline].1[end underline].

(b) – (j) No Change

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, 14108, 14108.1, 14108.2, 14110.6, 14110.7, 14124.5 and [begin strikeout]~~14126.23~~[end strikeout] [begin underline]14126.023[end underline], Welfare and Institutions Code. Reference: Sections 14105, [begin strikeout]~~14105.47,~~[end strikeout] 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7, [begin strikeout]~~14132~~[end strikeout] [begin underline] 14123 [end underline] and 14171, Welfare and Institutions Code; and Statutes of [begin strikeout]~~2002~~[end strikeout] [begin underline]2003[end underline], Chapter [begin strikeout]~~379~~[end strikeout] [begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890; and Sections 447.15 and 483.1, et seq., Title 42, Code of Federal Regulations.

(6) Amend Section 51511.5 to read as follows:

§ 51511.5. Nursing Facility Services – Subacute Care Reimbursement.

(a)(1) For the [begin strikeout]~~2002-03~~[end strikeout] [begin underline]2003-04[end underline] rate year, the prospective rate of reimbursement, which shall be the all-inclusive per diem 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 rate based on the class median rates continued from the prior year, as set forth below:

Type of Licensure Hospital-based

Type of Patient Ventilator dependent

Class Median Based Rate $580.07

Type of Licensure Freestanding

Type of Patient Ventilator dependent

Class Median Based Rate [begin strikeout]~~$397.71~~[end strikeout] [begin underline]$409.72[end underline]

Type of Licensure Hospital-based

Type of Patient Non-ventilator dependent

Class Median Based Rate $553.15

Type of Licensure Freestanding

Type of Patient Non-ventilator dependent

Class Median Based Rate [begin strikeout]~~$371.44~~[end strikeout] [begin underline]$381.45 [end underline]

(2)(A) For the [begin strikeout]~~2002-03~~[end strikeout][begin underline]2003-04[end underline]rate year, a facility that experienced a reduction in projected facility costs, which would result in a reduced subacute reimbursement rate for the [begin strikeout]~~2002-03~~[end strikeout][begin underline]2003-04[end underline] rate year pursuant to subsection (a)(1), shall have its subacute prospective reimbursement rate for [begin strikeout]~~2002-03~~[end strikeout][begin underline]2003-04[end underline]set at its [begin strikeout]~~2001-02~~[end strikeout][begin underline]2002-03[end underline] rate.

(a)(2)(B) – (d) No change

(e) For purposes of this section, the rate year is August 1,~~ 2002~~[begin underline]2003[end underline]through July 31, [begin strikeout]~~2003~~[end striketout][begin underline]2004[end underline].

(f)(1) The facility's projected costs for purposes of section (a) shall be based on the audit report findings of cost reports with fiscal periods ending January 1,-1999[begin underline]2000[end underline] through December 31, 1999 [begin underline]2000[end underline]. In the event that a facility's audit report finding does not include subacute ancillary costs, the facility's projected ancillary costs shall be based on the median of the subacute ancillary costs of facilities that had audited ancillary costs.

(2) If the audit of a cost report as described in subsection (f)(1) is not issued by July 1, [begin strikeout]~~2002~~[end strikeout][begin underline]2003[end underline], the Department shall establish the facility's interim costs based on the cost report with a fiscal period ending January 1, [begin strikeout] [end strikeout]~~1999~~ [begin underline]2000[end underline] through December 31, [begin strikeout]~~1999~~[end

strikeout][begin underline]2000[end underline], adjusted by an audit disallowance factor of [begin strikeout].95451[end strikeout] [begin underline].96101[end underline].

(3) The Department will use the facility's interim costs as the facility's projected costs for purposes of subsection (a). In addition, facilities that did not provide subacute care services to Medi-Cal patients during the cost report period, facilities that combine subacute and [begin strikeout]DP/NF[end strikeout] [begin underline]distinct part nursing facility Level B[end underline] costs, and/or facilities with less than a full year's reported cost shall not be included for purposes of establishing the projected class median costs.

(4) If the facility's interim costs, as specified in subsection (f)(2), are established for a facility 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 reimbursement rate retroactively to August 1, [begin strikeout]2002 [begin underline]2003,[end underline] to reflect the facility's costs determined pursuant to such an audit, or to reflect the costs in the cost report in the event that the cost report is deemed true and correct.

(5) Interest will accrue from August 1, [begin strikeout]2002[end strikeout][begin underline]2003[end underline], and be payable on any underpayment or overpayment resulting from the application of subsection (f)(4) at a rate equal to the monthly average received on investment in the Surplus Money Investment Fund (as referenced in Welfare and Institutions Code Section 14171) during the month the audit report is issued.

(6) If a provider appeals an audit adjustment pursuant to Welfare and Institutions Code Section 14171, and there is a 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 rate of reimbursement as provided in subsection (a).

(g) Payment under subsection (a) shall only be made for services authorized pursuant to conditions set forth in Section 513[begin strikeout]~~5~~[end strikeout][begin underline]3[end underline]5.5 for patients determined to need subacute care services.

Note: Authority cited: [begin underline] Section 20, Health and Safety Code; and [end underline] Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of [begin strikeout]~~2002~~[end strikeout][begin underline]2003 [end underline], Chapter 379[begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890.

(7) Amend Section 51511.6 to read as follows:

§ 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 Hospital-Based

Type of Patient Ventilator Dependent

Rate of Reimbursement

[begin strikeout]~~$705.30~~[end strikeout]

[begin underline]$719.71[end underline]

Licensure Hospital-Based

Type of Patient Non-Ventilator Dependent

Rate of Reimbursement

[begin strikeout]~~$647.62~~[end strikeout]

[begin underline]$660.52[end underline]

Licensure Freestanding

Type of Patient Ventilator Dependent

Rate of Reimbursement

[begin strikeout]~~$659.73~~[end strikeout]

[begin underline]$673.08[end underline]

Licensure Freestanding

Type of Patient Non-Ventilator Dependent

Rate of Reimbursement

[begin strikeout]~~$602.05~~[end strikeout]

[begin underline]$613.89[end underline]

(b) The per diem rate of reimbursement for supplemental rehabilitation therapy services shall be [begin strikeout]~~$42.40~~[end strikeout][begin underline]$43.13[end underline]. 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 [begin strikeout]~~$39.53~~[end strikeout][begin underline]$40.21[end underline]. This rate shall include respiratory care practitioner and nursing care services provided in accordance with Section 51215.11.

(d) – (f) No Change

Note: Authority cited: [begin underline]Section 20, Health and Safety Code; and[end underline] Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of [begin strikeout]~~2002~~[end strikeout] [begin underline]2003[end underline], Chapter [begin strikeout]~~379~~[end strikeout][begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890.

(8) Amend Section 51535 to read as follows:

§ 51535. Leave of Absence.

(a) – (c) No change

(d) Payment to skilled nursing facilities, swing bed facilities, intermediate care facilities, intermediate care facilities for the developmentally disabled, intermediate care facilities for the developmentally disabled-habilitative, and intermediate care facilities for the developmentally disabled-nursing for patients who are on approved leave of absence shall be at the appropriate facility daily rate less [begin strikeout]~~$4.95~~[end strikeout][begin underline]$5.05[end underline] for raw food costs, except for state operated institutions.

Note: Authority cited: [begin underline]Section 20, Health and Safety Code: and [end underline] Sections 10725, 14105, 14108, 14108.1, 14108.2 and 14124.5, Welfare and Institutions Code; and Section 1275.3, Health and Safety Code. Reference: Sections 14108, 14108.1, 14108.2, 14109.5 and 14110.1, Welfare and Institutions Code; Section 1275.3, Health and Safety Code; and Statutes of [begin strikeout]~~2002~~[end strikeout][begin underline]2003[end underline], Chapter [begin strikeout]~~379~~[end strikeout][begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890.

(9) Amend Section 51535.1 to read as follows:

§ 51535.1. Bed Hold for Acute Hospitalization.

(a) – (c) No Change

(d) Payment to skilled nursing facilities, swing bed facilities, intermediate care facilities for the developmentally disabled; intermediate care facilities for the developmentally disabled-habilitative, and intermediate care facilities for the developmentally disabled-nursing for beneficiaries who are on bed hold for acute hospitalization shall be at the appropriate facility daily rate less [begin strikeout] ~~$4.95~~[end strikeout] [begin underline]$5.05[end underline] for raw food costs, except for state operated institutions.

Note: Authority cited: Sections 10725, 14105, 14108, 14108.1, 14108.2, 14109.5 and 14124.5, Welfare and Institutions Code; and Section[begin underline]s 20 and[end underline] 1275.3, Health and Safety Code. Reference: Sections 14087.3, [begin underline]14105.981,[end underline] 14108, 14108.1, 14108.2, 14110.1[begin underline], 14123[end underline] and [begin strikeout]~~14132~~[end strikeout][begin underline]14132.22[end underline], Welfare and Institutions Code; Section 1275.3, Health and Safety Code; and Statutes of [begin strikeout]~~2002~~[end strikeout][begin underline]2003[end underline], Chapter [begin strikeout]~~379~~[end strikeout][begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890.

(10) Amend Section 51544 to read as follows:

§ 51544 Hospice Care.

(a) – (g) No Change

(h) Payment shall be made to a hospice provider for services rendered to an individual who is a resident of a Level A or Level B nursing facility at one or more of the levels of hospice care described in subsection (b), with the exception of respite care, and for physician services provided by the hospice which are not included in one of the levels of care. [begin strikeout ~~In addition, payment, not to exceed the following, shall be made to the hospice for room and board furnished by the nursing facility for each day the individual resides in the facility.~~ [end strikeout] [begin underline] Payment shall be 95 percent of the facility's Medi-Cal per diem rate where the patient resides. [end underline] [begin strikeout ~~(1) Operative August 1, 2002 to January 31, 2003, payment shall be:~~

~~Procedure Statewide~~

~~Code Rate~~

~~Level B Nursing Facility Z7110 $108.04~~

~~Level A Nursing Facility Z7112 $73.62~~

~~(2) Operative February 1, 2003, payment shall be 95 percent of the facility's Medi-Cal per diem rate where the patient resides.~~[end strikeout]

(i) – (j) No Change

Note: Authority cited: [begin underline]Section 20, Health and Safety Code; and[end underline] Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053 and [begin strikeout]~~14132~~[end strikeout] [begin

underline]14123[end underline], Welfare and Institutions Code; Statutes of ~~2002~~ [begin underline]2003[end underline], Chapter [begin strikeout]~~379~~[end strikeout][begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890; and 42 United States Code Section 1396a(a)(13)(B) [Section 1902(a)(13)(B) of the federal Social Security Act].

(11) Amend Section 54501 to read as follows:

§ 54501. Adult Day Health Care Services.

(a) No Change

(b) The maximum all-inclusive daily rate per day of attendance for each approved Medi-Cal participant shall be [begin strikeout]~~$68.57~~[end strikeout] [begin underline]$69.58[end underline].

(c) – (j) No Change

Note: Authority cited: [begin underline]Section 20, Health and Safety Code; and[end underline] Sections 10725, 14105, 14124.5 and 14570, Welfare and Institutions Code. Reference: Section 14571, Welfare and Institutions Code; Statutes of [begin strikeout]~~2002~~[end strikeout] [begin underline]2003[end underline], Chapter [begin strikeout]~~379~~[end strikeout][begin underline]157[end underline], Items 4260-101-0001 and 4260-101-0890; and the Settlement Agreement in *California Association for Adult Day Services v. Department of Health Services*, January 12, 1994, San Francisco County Superior Court (Case Number 944047).