§ 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) For facilities in the following counties the base rate is:

Los Angeles County $80.62

Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo

Santa Clara & Sonoma Counties $80.62

All Other Counties $$67.94

(2) 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.

(3) 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.

(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 14126.023, Welfare and Institutions Code. Reference: Sections 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7 and 14123, Welfare and Institutions Code; and Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890.

§ 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 according to the following daily rates. Payment for service includes the Quality Assurance Fee pursuant to Health and Safety Code Section 1324.2.

Total Licensed Beds	**7/1/03 – 7/31/03**
1-59	$141.19
60 Plus	$120.69
60 Plus with/Distinct Part	$120.69
Total Licensed Beds	**8/1/03**
1-59	$143.95
60 Plus	$123.87
60 Plus with/Distinct Part	$123.87

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

NOTE: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, 14108, 14110.6, 14110.7, 14124.5 and 14126.023, Welfare and Institutions Code. Reference: Sections 14087.3, 14108, 14109.5, 14110.4, 14110.6, 14110.7 and 14123, Welfare and Institutions Code; Sections 1250, 1324, 1324.2, 1324.4, 1324.8, 1324.10 and 1324.12, Health and Safety Code; and Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890.

§ 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. Payment for service includes the Quality Assurance Fee pursuant to Health and Safety Code Section 1324.2.

Total Licensed Beds	**7/1/03 – 7/31/03**
4-6	$163.45
7-15	$162.35

Total Licensed Beds	**8/1/03**
4-6	$163.45
7-15	$163.18

(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 14126.023, Welfare and Institutions Code. Reference: Sections 1250, 1267.7, 1324, 1324.2, 1324.4, 1324.6, 1324.8, 1324.10 and 1324.12, Health and Safety Code; Sections 14105.47, 14108, 14108.2, 14109.5, 14110.4, 14110.6 and 14123, Welfare and Institutions Code; and Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890.

§ 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. Payment for service includes the Quality Assurance Fee pursuant to Health and Safety Code Section 1324.2.

Total Licensed Beds	**7/1/03 – 7/31/03**
4-6	$200.28
7-15	$177.60

Total Licensed Beds	**8/1/03**
4-6	$200.28
7-15	$177.60

(a)(1) – (e) No change

Note: Authority cited: Sections 20, 1267.7 and 1275.3, Health and Safety Code; and Sections 10725, 14105, 14108, 14108.2, 14110.6, 14110.7, 14124.5 and 14126.023, Welfare and Institutions Code. Reference: Sections 1250, 1267.7, 1324, 1324.2, 1324.4, 1324.6, 1324.8, 1324.10, 1324.12 and 1324.14, Health and Safety Code; Sections 14108, 14108.2, 14109.5, 14110.4, 14110.6 and 14123, Welfare and Institutions Code; and Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890.

§ 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, for the 2003-04 rate year are as follows:

Bedsize	*1-59*	*Los Angeles County*	$107.06
Bedsize	*60 Plus*	*Los Angeles County*	$107.20
Bedsize	*1-59*	*Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara & Sonoma*	$132.57
Bedsize	*60 Plus*	*Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara & Sonoma*	$139.34
Bedsize	*1-59*	*All Other Counties*	$115.19
Bedsize	*60 Plus*	*All Other Counties*	$119.60

(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 $236.82.

(A) For purposes of this section, the rate year is August 1, 2003, through July 31, 2004.

(B) The facility's projected costs shall be based on the audit report findings of cost reports with fiscal periods ending January 1, 2001, through December 31, 2001. 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, 2003, 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, 2003, the Department shall establish an interim projected reimbursement rate based on the cost report with a fiscal period ending January 1, 2001, through December 31, 2001, adjusted by an audit disallowance factor of .96106.

(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, 2003, 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, 2003, 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 Institutions 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 $229.96.

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

(6) Reduced for bed hold provided pursuant to Section 51535.1.

(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 14126.023, Welfare and Institutions Code. Reference: Sections 14105, 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7, 14123 and 14171, Welfare and Institutions Code; and Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890; and Sections 447.15 and 483.1, et seq., Title 42, Code of Federal Regulations.

§ 51511.5. Nursing Facility Services – Subacute Care Reimbursement.

(a)(1) For the 2003-04 rate year, the prospective rate~~s~~ 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	$409.72
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	$381.45

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

(a)(2)(B) – (d) No change

(e) For purposes of this section, the rate year is August 1, 2003 through July 31, 2004.

(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, 2000 through December 31, 2000. In the event that a facility's audit report finding[begin strikeout]s[end strikeout] do[begin underline]es[end underline] 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, 2003, the Department shall establish the facility's interim costs based on the cost report with a fiscal period ending January 1, 2000 through December 31, 2000, adjusted by an audit disallowance factor of .96101.

(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 distinct part nursing facility Level B 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, 2003, 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, 2003, 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 [begin strikeout]~~subdivision~~[end strikeout][begin underline] subsection[end underline] (a).

(g) Payment under subsection (a) shall only be made for services authorized pursuant to conditions set forth in Section 51335.5 for patients determined to need subacute care services.

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890.

§ 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	$719.71
Licensure	Hospital-Based
Type of Patient	Non-Ventilator Dependent
Rate of Reimbursement	$660.52
Licensure	Freestanding
Type of Patient	Ventilator Dependent
Rate of Reimbursement	$673.08
Licensure	Freestanding
Type of Patient	Non-Ventilator Dependent

(b) The per diem rate of reimbursement for supplemental rehabilitation therapy services shall be $43.13. 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 $40.21. 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: Section 20, Health and Safety Code; and Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890.

§ 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 $5.05 for raw food costs, except for state operated institutions.

Note: Authority cited: Section 20, Health and Safety Code; and 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 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890.

§ 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 $5.05 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 Sections 20 and 1275.3, Health and Safety Code. Reference: Sections 14087.3, 14105.981, 14108, 14108.1, 14108.2, 14110.1, 14123 and 14132.22, Welfare and Institutions Code; Section 1275.3, Health and Safety Code; and Statutes of 2003, Chapter 157, Items 4260-101-0001 and 4260-101-0890.

§ 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. Payment shall be 95 percent of the facility's Medi-Cal per diem rate where the patient resides.

(i) – (j) No Change

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053 and 14123, Welfare and Institutions Code; Statutes of 2003, Chapter 157, 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].

§ 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 $69.58.

(c) – (j) No Change

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, 14124.5 and 14570, Welfare and Institutions Code. Reference: Section 14571, Welfare and Institutions Code; Statutes of 2003, Chapter 157, 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).