COMPUTATION OF

HOME HEALTH AGENCY RATES

EFFECTIVE AUGUST 1, 2000

REPORT NO. 01-00-13

Rate Development Branch
Medi-Cal Policy Division
Department of Health Services

July 2000

ACTION: Notice of Emergency Rulemaking

SUBJECT: **Long Term Care Rates (FY 2000-2001) (R-25-00E)**

PUBLIC PROCEEDINGS: Notice is hereby given that the California Department of Health Services will conduct written public proceedings, during which time any interested person or such person's duly authorized representative may present statements, arguments or contentions relevant to the action described in this notice. Any written statements, arguments or contentions must be received by the Office of Regulations, Department of Health Services, 714 P Street, Room 1000, P.O. Box 942732, Sacramento, CA 94234-7320, by 5 p.m. on January 16, 2001, which is hereby designated as the close of the written comment period. It is requested but not required that written statements, arguments or contentions sent by mail or hand-delivered be submitted in triplicate.

Comments by FAX (916-657-1459) or email (regulation@dhs.ca.gov) must be received before 5:00 p.m. on the last day of the public comment period. 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 in the regulation text on which additional comments may be solicited.

CONTACT: Inquiries concerning the action described in this notice may be directed to Barbara Gallaway, RN, MSN of the Office of Regulations at (916) 657-3197. In any such inquiries, please identify the action by using the Department regulation control number **R-25-00E**.

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.

INFORMATIVE DIGEST:

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

This emergency regulatory action amends regulations to implement reimbursement rate adjustments to reflect decisions within the allotted funds passed by the Legislature and approved by the Governor in the 2000-2001 Budget Act Items 4260-101-0001 and 4260-101-0890 (Statutes of 2000, Chapter 52). The individual rate adjustments amended the following Sections of Title 22, California Code of Regulations, and are described below as averages, weighted by actual patient days, for all the facility categories in that regulation section.

Section	Service	Annual Percentage Change
51510 (e)	Nursing Facility Level A Services	8.897
51510.1(d)	Intermediate Care Services for the Developmentally Disabled	13.906
51510.2(a)	Intermediate Care Services for the Developmentally Disabled-Habilitative	13.165
51510.3(a)	Intermediate Care Services for the Developmentally Disabled-Nursing	13.783
51511(a)	Nursing Facility Level B Services	16.884
51511.3	Nursing Facility Transitional Inpatient Care Acute Transitional Care	12.935 6.941
51511.5	Subacute	4.659
51511.6(a)	Pediatric Subacute	10.373
51523	Home Health Agency	10.000
51532.1	EPSDT & HCBS	10.000
51535(d)	Leave of Absence	3.463
51535.1(d)	Bed Hold for Acute Hospitalization	3.463

51544(h)	Hospice Care-NF-A	6.544
	Hospice Care-NF-B	16.972
54501(b)	Adult Day Health Care	4.543

The annual percentage change shown above is an average of all facility categories in each regulation section, weighted by patient days for those categories.

In regulation Sections 51511(a)(2)(C) and 51511.5(g) of this emergency action where an audit disallowance factor is used, the audit disallowance factor is based on audits of a random sample of facilities, reflects costs that are found not to be allowable costs to the Medi-Cal program, and is applied to all facilities in that regulation section.

Plain English Policy Statement Overview and Noncontrolling Plain English Summary

These emergency regulations increase the money Medi-Cal pays for certain services. The kinds of services affected are long term care and some home care services.

Authority: Sections 10725, 14105, 14108, 14108.1, 14108.2, 14110.6, 14110.7, 14124.5, 14126.23, and 14570, Welfare and Institutions Code; and Section 1275.3, 1267.7 and 100275, Health and Safety Code.

Reference: Sections 14053, 14059, 14087.3, 14105, 14105.981, 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7, 14132, 14132.22, 14132.25, 14171 and 14571, Welfare and Institutions Code; Sections 1250, 1250.1, 1267.7 and 1275.3, Health and Safety Code; Statutes of 2000, Chapter 52, Items 4260-101-0001 and 4260-101-0890; Sections 433.123, 447.15 and 483.1, et seq., Title 42, Code of Federal Regulations; 42 United States Code Section 1396d(r); *Coalition of Visiting Nurse Associations* v. *Department of Health Services*, Los Angeles County Superior Court (Case No. BC 22501) and *California Association for Adult Day Services* v. *Department of Health Services*, January 12, 1994, San Francisco County Superior Court (Case Number 944047). HHA lawsuit

FISCAL IMPACT ESTIMATE:

A. Fiscal Effect on Local Government: None.

B. Fiscal Effect on State Government: Additional expenditures of approximately $248,822,000 are anticipated for current state fiscal year. It is anticipated that the state agencies will be able to absorb $239,486,000 of these additional costs within their existing budgets and resources. It is anticipated that state agencies will request an increase in the currently authorized budget level for the 2000 – 2001 fiscal year of $9,336,000.

C. Fiscal Effect on Federal Funding of State Programs: Additional expenditures of approximately $242,740,000 in the current state Fiscal Year which includes an increase of $9,152,000 in federal funds.

D. Fiscal Effect on Private Persons or Businesses Directly Affected: There is no adverse economic impact on affected private persons or businesses because the rate changes for the levels of long term care covered by the Medi-Cal program are based upon the reported costs of providing services.

E. Other Nondiscretionary Cost or Savings Imposed on Local Agencies: 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 determined that the regulations would not have a significant adverse economic impact on businesses, including the ability of California businesses to compete with businesses in other states. 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.

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 may positively affect small business by increasing reimbursement rates for various health-related services. The changes, which adjust the maximum Medi-Cal rates for long term care (LTC) services, do not alter reimbursement policy for LTC facilities nor impose cost mandates on other businesses. Participation in the Medi-Cal program is voluntary both on the part of beneficiaries and providers.

The Department has also determined that it is not feasible to draft the regulations in plain English due to the technical nature of the regulations; however, a Plain English Policy Statement Overview and Noncontrolling Plain English Summary of the regulations is available from the Office of Regulations at the address noted above.

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

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. A copy of the initial statement of reasons and a copy of the text of the emergency regulations are available upon request by writing to the Office of Regulations at the address noted above, which address will also be the location of public records, including reports, documentation, and other material related to the emergency regulations.

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.

ADDITIONAL STATEMENTS AND COMMENTS: In accordance with Government Code Section 11346.5(a)(12) the Department must determine that no alternative considered by the Department would be more effective in carrying out the purpose for which the action was taken or would be as effective and less burdensome to affected private persons than the emergency action.

No hearing has been scheduled; however any interested person or his or her duly authorized representative may request, no later than 15 days prior to the close of the written comment period, a public hearing pursuant to Government Code Section 11346.8.

Sign language interpreting services at a public hearing or other reasonable accommodation will be provided upon request. Such request should be made no later than 21 days prior to the close of the written comment period, and addressed to the Office of Civil Rights within the Department of Health Services by phone (916-657-1411); FAX (916-657-0153); TDD (916-657-2861); or email (civilrights-ra@dhs.ca.gov).

DEPARTMENT OF HEALTH SERVICES

R-25-00E

Dated: November 6, 2000

Diana M. Bonta, R.N., Dr.P.H.
Director

FINDING OF EMERGENCY

These regulations are necessary to protect the health and safety of Medi-Cal beneficiaries for the reasons set forth below. Subdivision (a) of Section 14105 of the Welfare and Institutions Code 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 such rules and regulations as are necessary for carrying out, 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 which reflect such decisions within one month after the enactment of the Budget Act and of any other appropriation which changes the level of funding for Medi-Cal services. The proposed regulations shall be submitted to the Department of Finance no later than five days prior to the date of adoption. With the written approval of the Department of Finance, the director shall adopt such regulations as emergency regulations in accordance with the Administrative Procedure 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 such regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare."

This regulation package adopts new long term care rates in order to implement decisions made by the Legislature and approved by the Governor in the 2000-2001 Budget Act, Items 4260-101-0001 and 4260-101-0890 (Statutes of 2000, Chapter 52).

The rate adjustments protect the health, safety, and welfare of Medi-Cal beneficiaries who may need long term care by adequately reimbursing providers which, in turn, assures access to services.

INFORMATIVE DIGEST:

Section 14105, Welfare and Institutions Code, requires the Department to adopt regulations establishing reimbursement rates for Medi-Cal providers

of health care services and provides for the emergency adoption of regulations for these changes in response to legislative budgeting decisions.

This emergency regulatory action amends regulations to implement reimbursement rate adjustments to reflect decisions within the allotted funds passed by the Legislature and approved by the Governor in the 2000-2001 Budget Act Items 4260-101-0001 and 4260-101-0890 (Statutes of 2000, Chapter 52). The individual rate adjustments amended the following Sections of Title 22, California Code of Regulations, and are described below as averages, weighted by actual patient days, for all the facility categories in that regulation section.

Section	Service	Annual Percentage Change
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51510.3(a)	Intermediate Care Services for the Developmentally Disabled-Nursing	13.783
51511(a)	Nursing Facility Level B Services	16.884
51511.3	Nursing Facility Transitional Inpatient Care Acute Transitional Care	12.935 6.941
51511.5	Subacute	4.659
51511.6(a)	Pediatric Subacute	10.373
51523	Home Health Agency	10.000
51532.1	EPSDT & HCBS	10.000
51535(d)	Leave of Absence	3.463
51535.1(d)	Bed Hold for Acute Hospitalization	3.463
51544(h)	Hospice Care-NF-A Hospice Care-NF-B	6.544 16.972

54501(b)	Adult Day Health Care	4.543

The annual percentage change shown above is an average of all facility categories in each regulation section, weighted by patient days for those categories.

In regulation Sections 51511(a)(2)(C) and 51511.5(g) of this emergency action where an audit disallowance factor is used, the audit disallowance factor is based on audits of a random sample of facilities, reflects costs that are found not to be allowable costs to the Medi-Cal program, and is applied to all facilities in that regulation section.

Plain English Policy Statement Overview and Noncontrolling Plain English Summary

These emergency regulations increase the money Medi-Cal pays for certain services. The kinds of services affected are long term care and some home care services.

Authority: Sections 10725, 14105, 14108, 14108.1, 14108.2, 14110.6, 14110.7, 14124.5, 14126.23, and 14570, Welfare and Institutions Code; and Section 1275.3, 1267.7 and 100275, Health and Safety Code.

Reference: Sections 14053, 14059, 14087.3, 14105, 14105.981, 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7, 14132, 14132.22, 14132.25, 14171 and 14571, Welfare and Institutions Code; Sections 1250, 1250.1, 1267.7 and 1275.3, Health and Safety Code; Statutes of 2000, Chapter 52, Items 4260-101-0001 and 4260-101-0890; Sections 433.123, 447.15 and 483.1, et seq., Title 42, Code of Federal Regulations; 42 United States Code Section 1396d(r); *Coalition of Visiting Nurse Associations* v. *Department of Health Service,* Los Angeles County Superior Court (Case No. BC 22501) and *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 expenditures of approximately $248,822,000 are anticipated for current state fiscal year. It is anticipated that the state agencies will be able to absorb $239,486,000 of these additional costs within their existing budgets and resources. It is anticipated that state agencies will request an increase in the currently authorized budget level for the 2000 – 2001 fiscal year of $9,336,000.

C. Fiscal Effect on Federal Funding of State Programs: Additional expenditures of approximately $242,740,000 in the current state Fiscal Year which includes an increase of $9,152,000 in federal funds.

D. Fiscal Effect on Private Persons or Businesses Directly Affected: There is no adverse economic impact on affected private persons or businesses because the rate changes for the levels of long term care covered by the Medi-Cal program are based upon the reported costs of providing services.

E. Other Nondiscretionary Cost or Savings Imposed on Local Agencies: 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 determined that the regulations would not have a significant adverse economic impact on businesses, including the ability of California businesses to compete with businesses in other states. 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.

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 may positively affect small business by increasing reimbursement rates for various health-related services. The changes, which adjust the maximum Medi-Cal rates for long term care (LTC) services, do not alter reimbursement policy for LTC facilities nor impose cost mandates on other businesses. Participation in the Medi-Cal program is voluntary both on the part of beneficiaries and providers.

The Department has also determined that it is not feasible to draft the regulations in plain English due to the technical nature of the regulations; however, a Plain English Policy Statement Overview and Noncontrolling Plain English Summary of

the regulations is available from the Office of Regulations at the address noted above.

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

INITIAL STATEMENT OF REASONS

The following sections of Title 22, California Code of Regulations, are being amended to implement changes in maximum reimbursement rates for Medi-Cal providers as mandated by Items 4260-101-0001 and 4260-101-0890 of the Budget Act of 2000-2001 (Statutes of 2000, Chapter 52).

These changes are necessary to:

1. Implement Budget Act provisions relative to decisions permitting rate changes for long term care services provided to Medi-Cal beneficiaries. The new rates appear on pages 11 through 13 of the Reimbursement Study for Long Term Care Services prepared by the Department of Health Services (Report No. 01-00-04), and result in changes to the following Sections of Title 22, California Code of Regulations (CCR), except for Adult Day Health Care services which are changed in accordance with a litigation settlement agreement, EPSDT rates which are in Report No. 01-00-12 and Home Health Agency rates which are in Report No. 01-00-13. The percentage increases, as set forth in the Informative Digest, are weighted by actual patient days for each of the facility categories covered by the particular regulation section.

Section	Service	Explanation
51510(e)	Nursing Facility Level A Services	Changes rates for all bed size ranges
51510.1(d)	Intermediate Care Services for the Developmentally Disabled	Changes rates
51510.2(a)	Intermediate Care Services for the Developmentally Disabled-Habilitative	Changes rates
51510.3(a)	Intermediate Care Services for the Developmentally Disabled-Nursing	Changes rates
51511(a)	Nursing Facility Level B Services	Changes rates and dates for all bed sizes including distinct parts of acute hospitals and rural swing beds

51511.3(a),(b) and (c)	Transitional Inpatient Care Services	Changes rates for NFs and acute care
51511.5(a),(e),(f),(g),(i),(j) and (k)	Subacute	Changes rates and dates for all levels
51511.6(a),(b) and (c)	Pediatric Subacute	Changes rates
51523(a)	Home Health Agency	Changes rates
51532.1	EPSDT	Changes rates
51535(d)	Leave of Absence	Changes rate
51535.1(d)	Bed Hold for Acute Hospitalization	Changes rate
51544(h)	Hospice Care	Changes rates
54501(b)	Adult Day Health Care	Changes rate

2. Adjust the audit disallowance factor in regulation sections 51511(a)(2)(C) and 51511.5(g) of this emergency action. The audit disallowance factor is based on audits of a random sample of facilities, reflects costs that are found not to be allowable costs to the Medi-Cal program, and is applied to all facilities in that regulation section.

3. Comply with Section 14105 of the Welfare and Institutions Code which requires the Department to adopt implementing regulations within one month after enactment of any legislation that changes the level of funding for Medi-Cal services.

4. Comply with settlement agreement between California Association for Adult Day Services vs Department of Health Services of the State of California and Molly Joel Coye, M.D., Director, dated January 12, 1994.

The Department is relying upon the following supporting documentation for this emergency action:

1) Report No. 01-00-01 (Study To Develop Labor Index For Long Term Care Facilities)

2) Report No. 01-00-02 (Study To Determine The Add-on To Compensate For The Labor Shortage)

3) Report No. 01-00-03 (Study To Develop An Add-on For Elder Abuse Training)

4) Report No. 01-00-04 (Reimbursement Study--Long Term Care Services)

5) Report No. 01-99-05 (Revised), (Study To Develop Reimbursement For Increased Staffing Requirements Implemented January 1, 2000)

6) Report No. 01-00-06 (Study To Develop An Add-on For Overtime Law Change)

7) Report No. 01-00-07 (Study To Develop An Add-on For Workers Compensation)

8) Report No. 01-00-08 (Study To Develop An Add-on For Liability Insurance)

9) Report No. 01-00-09 (Study To Develop An Add-on For Intermediate Care Facilities For The Developmentally Disabled For Program Oversight)

10) Report No. 01-00-10 (Computation of Add-on For A 7.5 Percent Wage Pass Through For Rates Effective August 1, 2000)

11) Report No. 01-00-11 (Computation of Adult Day Health Care Rate, Effective August 1, 2000)

12) Report No. 01-00-12 (Computation of Rates for Early and Periodic Screening, Diagnosis and Treatment Supplemental Services (EPSDT) And Home and Community-Based Service (HCBS) Waivers, Effective August 1, 2000)

13) Report No. 01-00-13 (Computation of Home Health Agency Rates, Effective August 1, 2000)

Non-substantive changes have been made to update and correct the reference notes for all affected regulation sections.

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

STATEMENTS OF DETERMINATIONS

ALTERNATIVES CONSIDERED

In accordance with Government Code Section 11346.5(a)(12), the Department has determined that no alternative considered would be more effective in carrying out the purpose for which the emergency action was taken or would be as effective and less burdensome to affected private persons than the emergency action.

LOCAL MANDATE DETERMINATION

The Department has determined that the regulations do 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.

ECONOMIC IMPACT STATEMENT

In accordance with Government Code Section 11346.3, the Department has determined that the filing of these regulations does not have a significant adverse economic impact on businesses including the ability of California businesses to compete with businesses in other states. In addition, no California jobs or businesses will be created or eliminated nor current businesses expanded as a result of the proposed action. 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.

SMALL BUSINESS IMPACT STATEMENT

The Department has determined that the regulation changes may positively affect small business by increasing reimbursement rates for various health-related services. The changes, which adjust the maximum Medi-Cal rates for long term care (LTC) services, do not alter reimbursement policy for LTC facilities nor impose cost mandates on other businesses. Participation in the Medi-Cal program is voluntary both on the part of beneficiaries and providers.

The Department has also determined that it is not feasible to draft the regulations in plain English due to the technical nature of the regulations; however, a Plain English Policy Statement Overview and Noncontrolling Plain English Summary of the regulations is provided in the Informative Digest.

HOUSING COST IMPACT STATEMENT

The Department has determined that the regulations will not affect housing costs.

(1) Amend Section 51510(e) to read:

51510. Nursing Facility Level A Services.

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

(1) For facilities with licensed bed capacities and located by county as follows:

Bedsize	*Los Angeles County*	*Alameda, Contra Costa, Marin, San Francisco, San Mateo & Santa Clara Counties*	*All Other Counties*
1-99	~~$68.72~~ $72.96	~~$68.72~~ $72.96	~~$59.40~~ $65.98
100+	~~$77.64~~ $84.62	~~$77.64~~ $84.62	~~$77.64~~ $84.62

(2) and (3) no change

NOTE: Authority cited: Sections 10725, 14105, 14108, 14108.1, 14110.6, 14110.7, 14124.5 and 14126.23, Welfare and Institutions Code. Reference: Sections 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7 and 14132, Welfare and Institutions Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, Items 4260-101-0001 and 4260-101-0890.

(2) Amend Section 51510.1 (d) to read:

51510.1. Intermediate Care Services for the Developmentally Disabled.

(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 for services as indicated below.

Total Licensed Beds

~~Effective July 1, 2000:~~

1-59	*60+*	*60+ w/ Distinct Part*
~~$179.18~~	~~$145.60~~	~~$145.60~~

~~Effective August 1, 2000:~~

~~*1-59*~~	~~*60+*~~	~~*60+ w/ Distinct Part*~~
~~$117.36~~ $128.06	~~$92.25~~ $108.48	~~$92.25~~ $108.48

(1) and (2) no change

NOTE: Authority cited: Sections 10725, 14105, 14108, 14110.6, 14110.7, 14124.5 and 14126.23, Welfare and Institutions Code. Reference: Sections 14087.3, 14108, 14109.5, 14110.4, 14110.6, 14110.7 and 14132, Welfare and Institutions Code; Section 1250, Health and Safety Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, Items 4260-101-0001 and 4260-101-6890.

(3) Amend Section 51510.2(a) to read:

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 Sections 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:

Total Licensed Beds

4-6	*7-15*
~~$127.39~~ $144.08	~~$119.97~~ $136.47

(1) and (2) no change

NOTE: Authority cited: 10725, 14105, 14108, 14108.2, 14110.6, 14110.7, 14124.5 and 14126.23, Welfare and Institutions Code; and Section 1267.7, Health and Safety Code. Reference: Sections 14108, 14108.2, 14109.5, 14110.4, 14110.6 and 14132, Welfare and Institutions Code; Sections 1250 and 1267.7, Health and Safety Code; and Statutes of ~~1998~~ 2000, Chapter ~~324~~ 52, Items 4260-101-0001 and 4260-101-0890.

(4) Amend Section 51510.3(a) to read:

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:

Total Licensed Beds

~~Effective July 1, 2000:~~

4-6	*7-15*
~~$159.06~~	~~$189.19~~

~~Effective August 1, 2000:~~

~~4-6~~	~~7-15~~
~~$159.06~~ $181.57	~~$148.60~~ $159.60

(1) and (2) no change

NOTE: Authority cited: Sections 10725, 14105, 14124.5 and 14126.23, Welfare and Institutions Code; and Section 1275.3, Health and Safety Code. Reference: Sections 14105, 14108 and 14132, Welfare and Institutions Code; Sections 1250.1 and 1275.3, Health and Safety Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, Items 4260-101-0001 and 4260-101-0890.

(5) Amend Section 51511(a) to read:

51511. Nursing Facility Level B Services.

(a) no change

(1) For facilities with licensed bed capacities and located by county as follows:

Bedsize	*Los Angeles County*	*Alameda, Contra Costa, Marin, San Francisco, San Mateo & Santa Clara Counties*	*All Other Counties*
1-59	~~$87.26~~ $99.97	~~$100.28~~ $120.65	~~$93.31~~ $106.82
60+	~~$85.93~~ $100.48	~~$107.22~~ $126.55	~~$96.62~~ $112.82

(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 ~~$221.64~~ $230.29.

(A) For purposes of this section, the rate year is August 1, ~~1999~~ 2000, through July 31, ~~2000~~ 2001.

(B) The facility's projected cost shall be based on the audit report findings of cost reports with fiscal periods ending January 1, 199~~7~~8, through December 31, 199~~7~~8. 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, ~~1999~~ 2000, 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 cost shall be based on the modified audit findings.

(C) If the audit of a cost report is not issued by July 1, ~~1999~~ 2000, the Department shall establish an interim projected reimbursement rate based on the cost report with a fiscal period ending January 1, 199~~7~~8 through December 31, 199~~7~~8 adjusted by an audit disallowance factor of ~~.93649~~ .97407.

(D) no change

(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, ~~1999~~ 2000 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, ~~1999~~ 2000 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 the Welfare & Institutions Code Section 14171) during the month the audit report is issued.

(G) no change

(H) no change

(3) no change

(4) For facilities that are designated as swing bed facilities, the rate is ~~$198.91~~ $211.44.

(5) and (6) no change

(b) through (j) no change

NOTE: Authority cited: Sections 10725, 14105, 14108, 14108.1, 14108.2, 14110.6, 14110.7, 14124.5 and 14126.23, Welfare and Institutions Code. Reference: Sections 14105, 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7, 14132 and 14171, Welfare and Institutions Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, 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 51511.3 to read:

51511.3 Transitional Inpatient Care Services Reimbursement.

(a) The per diem reimbursement to freestanding certified nursing facilities and general acute care hospitals with distinct-part skilled nursing beds for transitional medical care and transitional rehabilitation care provided in accordance with Section 51215.6 shall be ~~$370.25~~ $418.14.

(b) The per diem reimbursement to general acute care hospitals for transitional medical care and transitional rehabilitation care provided in accordance with Sections 51215.6, and 51542(b) if applicable, shall be the hospital's inpatient services reimbursement or ~~$362.63~~ $387.80, depending on the following criteria:

TRANSITIONAL INPATIENT CARE (TC)

HFPA TRIGGERING

FACILITY	NO TC CONTRACTOR HFPA IS NOT TRIGGERED	TC CONTRACT AWARDED HFPA TRIGGERED TC BEDS UNAVAILABLE*	TC CONTRACT AWARDED HFPA TRIGGERED TC BEDS AVAILABLE
Hospital with TC contract	Not Applicable	~~$362.63~~ $387.80	~~$362.63~~ $387.80 May transfer patient
Hospital without TC contract	Retain patient at Hospital Inpatient Services Reimbursement**	the same rate as in (b) above***	No TC Authorization****

* Transitional inpatient care beds may not be available because all the beds in the transitional inpatient care units are occupied, or facilities may not accept the patient due to level of care or staffing considerations.

** The hospital inpatient services reimbursement for contracted hospitals as provided in Article 2.7 of the Welfare and Institutions Code shall be the rate specified in the hospital contract. The hospital inpatient services reimbursement for non-contract hospitals is set forth in Article 7.5 of Title 22 California Code of Regulations. Reimbursement at this level will be made if the hospital is not in an area triggered as provided in subsection (b)(3).

*** Acute administrative day process applies as specified in the Manual of Criteria for Medi-Cal authorization.

**** Transitional inpatient care days will not be authorized in this circumstance.

(1) and (2) no change.

(3) The Department will reimburse general acute care hospitals for transitional inpatient care services, provided in licensed acute care hospital beds, at the hospital inpatient services reimbursement rate until there is a contracted transitional inpatient care provider within the general acute care hospital's Health Facility Planning Area (HFPA) as developed by the Office of Statewide Health Planning and Development pursuant to Health and Safety Code Sections 127000 et seq. If a general acute care hospital is within 15 miles (which shall be defined as 30 minutes at 30 miles per hour) of a health facility in a neighboring HFPA that contracts to provide transitional inpatient care, the hospital will be considered within the contracted health facility's HFPA and subject to the provisions of transitional inpatient care reimbursement. The HFPA shall be triggered for transitional inpatient care when a provider is awarded a contract to provide transitional medical care. The HFPA shall be triggered for transitional rehabilitation care when a provider is awarded a contract to provide transitional rehabilitation care. The word "triggered" means that there is a contracted transitional inpatient care provider in the HFPA, and general acute care hospitals within that HFPA, or neighboring HFPA, as specified, will receive

the transitional inpatient care reimbursement of ~~$362.63~~ $387.80 for the care rendered to qualified patients if:

(A) and (B) no change.

(4) For general acute care hospitals that contract for the provision of transitional inpatient care services provided in licensed general acute care hospital beds, the Department will reimburse the transitional inpatient care per diem of ~~$362.63~~ $387.80 when the general acute care hospital's HFPA is designated a triggered area.

(5) no change

(c) no change

(1) no change

(2) Hospitals, without a negotiated contract for transitional inpatient care, shall receive the administrative day reimbursement of ~~$362.63~~ $387.80 for the provision of transitional inpatient care to Medi-Cal patients as long as placement attempts to facilities with a transitional inpatient care contract are documented.

(d) through (j) no change

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14105.981 and 14132.22, Welfare and Institutions Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, Items 4260-101-0001 and 4260-101-0890.

(7) Amend Section 51511.5 to read:

51511.5 **Nursing Facility Services--Subacute Care Reimbursement**

(a) 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 prospective class median rates of:

Type of Licensure	*Type of Patient*	*Rate of Reimbursement*
Hospital-based	Ventilator dependent	~~$549.03~~ $565.53
Freestanding	Ventilator dependent	~~$368.09~~ $397.71
Hospital-based	Non-ventilator dependent	~~$523.62~~ $540.12
Freestanding	Non-ventilator dependent	~~$343.37~~ $371.44

(b) through (d) no change

(e) For purposes of this section, the rate year is August 1, ~~1999~~ 2000 through July 31, ~~2000~~ 2001.

(f) The facility's projected cost shall be based on the audit report findings of cost reports with fiscal periods ending January 1, 199~~5~~ 7 through December 31, 199~~5~~ 7. In the event that a facility's audit report findings do not include subacute ancillary costs, the facility's projected ancillary cost will be based on the median of the subacute ancillary costs of facilities that had audited ancillary cost.

(g) If the audit of a cost report is not issued by July 1, ~~1998~~ 2000, the Department shall establish an interim projected reimbursement rate based on the cost report with a

fiscal period ending January 1, 1996~~6~~7 through December 31, 1996~~6~~7, adjusted by an audit disallowance factor of ~~.93649~~ .97407.

(h) no change

(i) If the facility has an interim reimbursement rate as specified in (g), when the audit report is issued or when the cost report is deemed true and correct under Welfare and Institutions Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to August 1, ~~1999~~ 2000 to reflect the cost determined pursuant to such audit, or to reflect the cost in the cost report in the event that cost report is deemed true and correct.

(j) Interest will accrue from August 1, ~~1999~~ 2000 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 the Welfare & Institutions Code Section 14171) during the month the audit report is issued.

(k) and (l) no change

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, Items 4260-101-0001 and 4260-101-0890.

(9) Amend Section 51523(a) to read:

51523. Home Health Agency Services.

(a) An approved home health agency shall be reimbursed in accordance with the maximum rates as shown below. However, in no case shall the services billed exceed charges made to the general public for the provision of similar services.

Procedure Code	*Per Visit Allowance*	*Maximum Rates*
Z6900	Skilled Nursing Services	~~$68.05~~ $74.86
Z6902	Home Health Aide Services	~~$41.59~~ $45.75
Z6904	Physical Therapy Services	~~$62.58~~ $68.84
Z6906	Occupational Therapy Services	~~$64.87~~ $71.36
Z6908	Speech Therapy Services	~~$71.30~~ $78.43
Z6910	Medical Social Services	~~$87.47~~ $96.22
Z6914	Case Evaluation and Initial Treatment Plan	~~$27.39~~ $30.13
Z6916	Monthly Case Evaluation Extension of Treatment Plan	~~$13.81~~ $15.19
Z6918	Unlisted Services	By Report
Z6920	Early Discharge Visit	~~$68.05~~ $74.86

(8) Amend Section 51511.6 to read:

51511.6. Nursing Facility Services - Pediatric Subacute Care Reimbursement.

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

Licensure	*Type of Patient*	*Rate of Reimbursement*
Hospital-Based	Ventilator Dependent	~~$621.61~~ $681.58
Hospital-Based	Non-Ventilator Dependent	~~$567.80~~ $626.14
Freestanding	Ventilator Dependent	~~$577.74~~ $635.93
Freestanding	Non-Ventilator Dependent	~~$523.93~~ $580.49

(b) The per diem rate of reimbursement for supplemental rehabilitation therapy services shall be ~~$39.74~~ $40.77. 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 ~~$37.05~~ $38.01. This rate shall include respiratory care practitioner and nursing care services provided in accordance with Section 51215.11.

(d) through (f) no change

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, Items 4260-101-0001 and 4260-101-0890.

NOTE: Authority cited: Sections 10725, 14105, and 14124.5, Welfare and Institutions Code. Reference: Sections 14105 and 14132.42, Welfare and Institutions Code; Statutes of ~~1995~~ 2000, Chapter ~~303~~ 52, Items 4260-101-0001 and 4260-101-0890; Section 433.123, Title 42, Code of Federal Regulations; and *Coalition of Visiting Nurse Associations v. Department of Health Services*, ~~lawsuit,~~ Los Angeles County Superior Court (Case No. BC 22501).

(10) Amend Section 51532.1 to read:

51532.1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services Provided by Registered Nurses, Licensed Vocational Nurses and Certified Home Health Aides.

(a) no change

(b) Reimbursement for EPSDT supplemental nursing services and home health aide services provided by a home health agency shall be as follows:

Procedure Code	Description	Hourly Rate	
Z5832	Registered Nurse	~~$36.88~~	$40.57
Z5834	Licensed Vocational Nurse	~~$26.74~~	$29.41
Z5836	Registered Nurse providing supervision	~~$41.30~~	$45.43
Z5838	Home Health Aide	~~$17.18~~	$18.90

(c) Reimbursement for EPSDT supplemental nursing services provided by licensed registered nurses and licensed vocational nurses enrolled as EPSDT supplemental services providers acting within the scope of their practice, under the written order and direction of the patient's treating physician pursuant to Section 51242, shall be as follows:

Procedure Code	Description	Hourly Rate	
Z5804	Registered Nurse	~~$29.04~~	$31.94
Z5806	Licensed Vocational Nurse	~~$22.20~~	$24.42
Z5840	Registered Nurse providing supervision	~~$32.52~~	$35.77

(d) no change

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code; Section 100275, Health and Safety Code. Reference: Sections 14059 and 14132, Welfare and Institutions Code; ~~and~~ 42 United States Code, Section 1396d(r); and Statutes of 2000, Chapter 52, Items 4260-101-0001 and 4260-101-0890.

(11) Amend Section 51535(d) to read:

51535. Leave of Absence.

(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 ~~$4.62~~ $4.78 for raw food costs, except for state operated institutions.

NOTE: Authority cited: 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 ~~1999~~ 2000, Chapter ~~50~~ 52, Items ~~4260-101-0001~~ and ~~4260-101-0890~~.

(12) Amend Section 51535.1(d) to read:

51535.1. Bed Hold for Acute Hospitalization and Transitional Inpatient Care.

(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 or transitional inpatient care shall be at the appropriate facility daily rate less ~~$4.62~~ $4.78 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 1275.3, Health and Safety Code. Reference: Sections 14087.3, 14105.981, 14108, 14108.1, 14108.2, 14110.1, 14132 and 14132.22, Welfare and Institutions Code; Section 1275.3, Health and Safety Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, Items 4260-101-0001 and 4260-101-0890.

(13) Amend Section 51544(h) to read:

51544. Hospice Care.

(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. In addition, the payments 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.

	Procedure Code	*Statewide Rate*
Level B Nursing Facility	Z7110	~~$89.56~~ $104.76
Level A Nursing Facility	Z7112	~~$67.15~~ $71.54

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053 and 14132, Welfare and Institutions Code; Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, Items 4260-101-0001 and 4260-101-0890.

(14) Amend Section 54501(b) to read:

54501. Adult Day Health Care Services.

(b) The maximum all-inclusive daily rate per day of attendance for each approved Medi-Cal participant shall be ~~$63.62~~ $66.51.

NOTE: Authority cited: Sections 10725, 14105, 14124.5 and 14570, Welfare and Institutions Code. Reference: Section 14571, Welfare and Institutions Code; and Statutes of ~~1999~~ 2000, Chapter ~~50~~ 52, 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).