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

DAVID MAXWELL-JOLLY
Director

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	**Service**	**Weighted Average Percentage Change**
51510 (e)	Nursing Facility Level A Services	1.47
51510.1(d) & (e)	Intermediate Care Services for the Developmentally Disabled	2.38
51510.2(a)	Intermediate Care Services for the Developmentally Disabled-Habilitative	0.00
51510.3(a)	Intermediate Care Services for the Developmentally Disabled-Nursing	0.00
51511(a)	Nursing Facility Level B Services 2003-04	3.92
51511.5(a), (e) (f) & (g)	Nursing Facility Services – Subacute Care Reimbursement	0.82
51511.6(a), (b) & (c)	Nursing Facility Services – Pediatric Subacute Care Reimbursement	2.00
51535(d)	Leave of Absence	2.02
51535.1(d)	Bed Hold for Acute Hospitalization	2.02
51544(h)	Hospice Care	N/A
54501(b)	Adult Day Health Care Services	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.O. 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.

DEPARTMENT OF HEALTH CARE SERVICES

DHCS-03-030E

Originally Signed

Dated: May 11, 2010

David Maxwell-Jolly
Director

DHCS-03-030E
March 15, 2010

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.”

<u>INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW</u>

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	Service	Weighted Average Percentage Change
51510 (e)	Nursing Facility Level A Services	1.47
51510.1(d) & (e)	Intermediate Care Services for the Developmentally Disabled	2.38
51510.2(a)	Intermediate Care Services for the Developmentally Disabled-Habilitative	0.00
51510.3(a)	Intermediate Care Services for the Developmentally Disabled-Nursing	0.00
51511(a)	Nursing Facility Level B Services 2003-04	3.92

Section	Service	Weighted Average Percentage Change
51511.5(a), (e) (f) & (g)	Nursing Facility Services – Subacute Care Reimbursement	0.82
51511.6(a), (b) & (c)	Nursing Facility Services – Pediatric Subacute Care Reimbursement	2.00
51535(d)	Leave of Absence	2.02
51535.1(d)	Bed Hold for Acute Hospitalization	2.02
51544(h)	Hospice Care	N/A
54501(b)	Adult Day Health Care Services	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.

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(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.

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51510.1(d) & (e)	Intermediate Care Services for the Developmentally Disabled	2.38
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51510.3(a)	Intermediate Care Services for the Developmentally Disabled-Nursing	0.00

Section	Service	Weighted Average Percentage Change
51511(a)	Nursing Facility Level B Services 2003-04	3.92
51511.5(a), (e) (f) & (g)	Nursing Facility Services – Subacute Care Reimbursement	0.82
51511.6(a), (b) & (c)	Nursing Facility Services – Pediatric Subacute Care Reimbursement	2.00
51535(d)	Leave of Absence	2.02
51535.1(d)	Bed Hold for Acute Hospitalization	2.02
51544(h)	Hospice Care	N/A
54501(b)	Adult Day Health Care Services	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	Service	Description
51510(e)(1)	Nursing Facility Level A Services	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.
51510(e)(2)	Nursing Facility Level A Services	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.
51510(e)(3)	Nursing Facility Level A Services	Moves the content of paragraph (2) to paragraph (3) and amends the language for clarity and parallel construction.

Section	Service	Description
51510(e)(4)	Nursing Facility Level A Services	Moves the content of paragraph (3) to paragraph (4) and amends the language for clarity and parallel construction.
51510.1(d)	Intermediate Care Services for the Developmentally Disabled	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).
51510.1(e)	Intermediate Care Services for the Developmentally Disabled	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.
51510.2(a)	Intermediate Care Services for the Developmentally Disabled-Habilitative	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.
51510.3(a)	Intermediate Care Facilities for the Developmentally Disabled – Nursing	Amends rates to reflect updated facility cost data and the QAF. Adds reference to H&S Code Section 1324.2 for the QAF program,

Section	Service	Description
		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.
51511(a)(1)	Nursing Facility Level B Services	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.
51511(a)(2)	Nursing Facility Level B Services	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”.
51511(a)(4)	Nursing Facility Level B Services	Amends designated swing bed facilities rates.
51511(a)(6)	Nursing Facility Level B Services	Includes a non-substantial change to correct an existing inaccurate cross reference.
51511.5(a)	Nursing Facility Services-Subacute Care Reimbursement	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.
51511.5(e) & (f)	Nursing Facility Services – Subacute Care Reimbursement	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.
51511.5(g)	Nursing Facility Services – Subacute Care Reimbursement	Specifies a non-substantial change to correct an existing inaccurate cross reference.

Section	Service	Description
51511.6(a), (b), & (c)	Nursing Facility Services – Pediatric Subacute Care Reimbursement	Amends rates based on a model which estimates expected costs. (Refer to last paragraph under heading below: Annual Long-Term Care Reimbursement Methodology)
51535(d)	Leave of Absence	Amends the rate based on the Consumer Price Index (CPI) applicable for the 2003-04 rate period.
51535.1(d)	Bed Hold for Acute Hospitalization	Amends the rate based on the CPI applicable for the 2003-04 rate period.
51544(h)	Hospice Care	Implements the Centers for Medicare & Medicaid Services (CMS) allowable reimbursement rate for hospice care and removes existing language that is no longer accurate.
54501(b)	Adult Day Health Care Services	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

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.

(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) ~~For facilities with licensed bed capacities and located by county as follows:~~ For facilities in the following counties the base rate is:

~~*Bedsize*~~	*Los Angeles County*	*Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara & Sonoma Counties*	*All Other Counties*
~~1-99~~	$80.62	$80.62	$67.94
~~100+~~	~~$89.54~~	~~$89.54~~	~~$85.54~~

(2) ~~Reduced for leave of absence provided pursuant to Section 51535.~~ 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) ~~Reduced for bed hold provided pursuant to Section 51535.1.~~ 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 ~~14126.23~~ 14126.023, Welfare and Institutions Code. Reference: Sections ~~14105.47~~, 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7 and ~~14132~~ 14123, Welfare and Institutions Code; and Statutes of ~~2002~~ 2003, Chapter ~~379~~ 157, 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 ~~for services as indicated below~~ 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	*60+*	*60+ w/Distinct Part*
~~$128.86~~ $141.19	~~$110.15~~$120.69	~~$110.15~~$120.69

8/1/03

$143.95	$123.87	$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) ~~Effective October 1, 1990, state operated facilities shall be entitled to payment for services at actual allowable cost.~~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 ~~14126.23~~ 14126.023, Welfare and Institutions Code. Reference: Sections 14087.3, ~~14105.47,~~ 14108, 14109.5, 14110.4, 14110.6, 14110.7 and ~~14132~~ 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 ~~2002~~ 2003, Chapter ~~379~~ 157, 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~~:~~. Payment for service includes the Quality Assurance Fee pursuant to Health and Safety Code Section 1324.2.

Total Licensed Beds

	4-6	7-15
7/1/03 – 7/31/03	~~$149.17~~$163.45	~~$148.17~~$162.35
8/1/03	$163.45	$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 ~~14126.23~~ 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 ~~14132~~ 14123, Welfare and Institutions Code; and Statutes of ~~2001~~2003, Chapter ~~106~~157, 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~~:~~. 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	7-15
~~$182.79~~$200.28	~~$162.09~~$177.60

8/1/03

$200.28	$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 ~~14126.23~~ 14126.023, Welfare and Institutions Code. Reference: Sections ~~1250.1 and 1275.3~~ 1250, 1267.7, 1324, 1324.2, 1324.4, 1324.6, 1324.8, 1324.10, 1324.12 and 1324.14, Health and Safety Code; Sections ~~14105, 14105.47,~~ 14108, 14108.2, 14109.5, 14110.4, 14110.6 and ~~14132~~ 14123, Welfare and Institutions Code; and Statutes of ~~2001~~ 2003, Chapter ~~106~~ 157, 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, for the 2003-04 rate year are as follows:

Bedsize	*Los Angeles County*	*Alameda, ContraCosta Marin,Napa, SanFrancisco San Mateo, Santa Clara & Sonoma Counties*	*All Other Counties*
1-59	~~$104.39~~$107.06	~~$129.96~~$132.57	~~$113.98~~$115.19
60+	~~$103.54~~$107.20	~~$131.08~~$139.34	~~$115.21~~$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 ~~$236.38~~ $236.82.

(A) For purposes of this section, the rate year is August 1, ~~2002~~2003, through July 31, ~~2003~~ 2004.

(B) The facility's projected costs shall be based on the audit report findings of cost reports with fiscal periods ending January 1, ~~2000,~~ 2001, through December 31, ~~2000~~ 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, ~~2002~~ 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, ~~2002~~ 2003, the Department shall establish an interim projected reimbursement rate based on the cost report with a fiscal period ending January 1, ~~2000~~ 2001, through December 31, ~~2000~~ 2001, adjusted by an audit disallowance factor of ~~.95451~~ .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, ~~2002~~ 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, ~~2002~~ 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 ~~$226.59~~ $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 ~~14126.23~~ 14126.023, Welfare and Institutions Code. Reference: Sections 14105, ~~14105.47,~~ 14108, 14108.1, 14108.2, 14109.5, 14110.1, 14110.4, 14110.6, 14110.7, ~~14132~~ 14123 and 14171, Welfare and Institutions Code; and Statutes of ~~2002~~ 2003, Chapter ~~379~~ 157, 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 ~~2002-03~~ 2003-04 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	*Type of Patient*	*Class Median-Based Rate*
Hospital-based	Ventilator dependent	$580.07
Freestanding	Ventilator dependent	~~$397.71~~$409.72
Hospital-based	Non-ventilator dependent	$553.15
Freestanding	Non-ventilator dependent	~~$371.44~~$381.45

(2)(A) For the ~~2002-03~~ 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 ~~2002-03~~ 2003-04 rate year pursuant to subsection (a)(1), shall have its subacute prospective reimbursement rate for ~~2002-03~~ 2003-04 set at its ~~2001-02~~ 2002-03 rate.

(a)(2)(B) – (d) No change

(e) For purposes of this section, the rate year is August 1, ~~2002~~ 2003 through July 31, ~~2003~~ 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, ~~1999~~2000 through December 31, ~~1999~~2000. 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, ~~2002~~ 2003, the Department shall establish the facility's interim costs based on the cost report with a fiscal period ending January 1, ~~1999~~ 2000 through December 31, ~~1999~~ 2000, adjusted by an audit disallowance factor of ~~.95451~~ .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 ~~DP/NF~~ 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, ~~2002~~ 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, ~~2002~~ 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 subsection (a).

(g) Payment under subsection (a) shall only be made for services authorized pursuant to conditions set forth in Section 513~~5~~35.5 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 ~~2002~~ 2003, Chapter ~~379~~157, 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	*Type of Patient*	*Rate of Reimbursement*
Hospital-Based	Ventilator Dependent	~~$705.30~~ $719.71
Hospital-Based	Non-Ventilator Dependent	~~$647.62~~ $660.52
Freestanding	Ventilator Dependent	~~$659.73~~ $673.08
Freestanding	Non-Ventilator Dependent	~~$602.05~~ $613.89

(b) The per diem rate of reimbursement for supplemental rehabilitation therapy services shall be ~~$42.40~~ $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 ~~$39.53~~ $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 ~~2002~~ 2003, Chapter ~~379~~ 157, 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 ~~$4.95~~ $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 ~~2002~~ 2003, Chapter ~~379~~ 157, 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 ~~$4.95~~ $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, 14108, 14108.1, 14108.2, 14110.1, 14123 and ~~14132~~ 14132.22, Welfare and Institutions Code; Section 1275.3, Health and Safety Code; and Statutes of ~~2002~~ 2003, Chapter ~~379~~ 157, 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. ~~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.~~ Payment shall be 95 percent of the facility's Medi-Cal per diem rate where the patient resides.

~~(1) Operative August 1, 2002 to January 31, 2003, payment shall be:~~

	~~Procedure Code~~	~~Statewide 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.~~

(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 ~~14132~~ 14123, Welfare and Institutions Code; Statutes of ~~2002~~ 2003, Chapter ~~379~~ 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].

(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 ~~$68.57~~ $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 ~~2002~~ 2003, Chapter ~~379~~ 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).