MEDI-CAL UPDATE

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New Reimbursement Rates for Institutes of Mental Disease Services

Assembly Bill (AB) 360 (Statutes of 2005, Chapter 508) mandates that the Institutions for Mental Disease (IMD) rates of payment are based on the Medi-Cal rates in effect on July 31, 2004. AB 360 also mandates an annual increase of 6.5 percent to IMD rates beginning July 1, 2005 through June 30, 2008. Beginning July 1, 2008, the annual increase will be 4.7 percent.

Accordingly, effective retroactively to July 1, 2005, the IMD rates are increased by 6.5 percent. *The updated information is reflected on manual replacement pages rate facil 7 (Part 2) and rate facil diem 2 (Part 2).*

Supplemental Schedules Required for AB 1629 Rate Methodology

Assembly Bill (AB) 1629 Rate-Setting Requires Supplemental Schedules
AB 1629 requires that the California Department of Health Services (CDHS) develop Medi-Cal cost-based, facility-specific reimbursement rates for Free-Standing Nursing Facilities Level-B (FS/NF-B) and subacute care units of FS/NF-Bs.

Welfare and Institutions Code (W&I Code), Section 14126.023(a), identifies the following five cost categories for setting facility-specific rates. Cost category headings are: 1) labor; 2) indirect care non-labor; 3) administrative; 4) capital costs (using a fair rental value system); and 5) direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance projected on the prior year's costs.

W&I Code, Section 14126.023(g), authorizes CDHS to collect supplemental information to implement this rate methodology. In order to accurately distinguish facility costs for the five cost categories, supplemental schedules are required.

W&I Code, Section 14126.027(c), authorizes CDHS to utilize Medi-Cal provider bulletins for implementation of the cost-based, facility-specific rate methodology.

Purpose of Supplemental Schedules
Certain costs are not currently identifiable on the *Office of Statewide Health Planning and Development* (OSHPD) *Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report* (OSHPD Report). Until the OSHPD Report is revised to specifically identify these costs, FS/NF-Bs and subacute care units of FS/NF-Bs are required to complete separate annual supplemental schedules detailing these expenditures. The *Administration Costs Supplemental Schedule* and *Indirect Care Services Supplemental Schedule,* as well as instructions for completing each supplemental schedule, may be accessed for download at the CDHS Web site's Long-Term Care System Development Unit page at **www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**.

Please see **AB 1629**, *page 2*

AB 1629 *(continued)*

In addition to the two required supplemental schedules noted above, a voluntary supplemental schedule detailing major capital improvements, modifications or renovations may be completed by providers that meet expenditure thresholds. The *Capital Additions, Improvements and Replacements Supplemental Schedule* and related instructions will define the expenditure and time period thresholds. This new voluntary schedule will be available soon for download at the Web page cited above.

Supplemental Schedules Reporting Period

For the rate year beginning August 1, 2006, facility-specific reimbursement rates will be based on data submitted by each FS/NF-B's OSHPD Report with a fiscal period end date in 2004. Information submitted on the supplemental schedules should be based on the identical time period as the facility's OSHPD Report with a fiscal period end date in 2004. If an FS/NF-B or a subacute care unit of an FS/NF-B submitted more than one OSHPD Report with a fiscal period end date in 2004, the facility must complete the required supplemental schedules for the most recent reporting period containing at least six months of data.

Format for Download and Submission
(Electronic submission to the supp1629@dhs.ca.gov e-mail address is required.)

It is critical that supplemental schedules be submitted to CDHS in a standardized electronic format and in a timely manner. Providers should download the supplemental schedules in the prescribed Excel format from the CDHS Long-Term Care System Development AB 1629 Web page at **www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm** and submit completed versions of the electronic supplemental schedules to CDHS via an e-mail address created specifically for these documents – **supp1629@dhs.ca.gov**. The electronic file should be labeled according to the supplemental schedule instructions posted on the Web site. If electronic download and submission is not available, the provider should contact (916) 552-8613 for further instructions about transmitting these data.

Due Date – April 3, 2006

All supplemental schedules are due to CDHS by **April 3, 2006**. The information on the supplemental schedules is required to calculate certain cost categories in each facility-specific Medi-Cal reimbursement rate for FS/NF-Bs and subacute care units of FS/NF-Bs subject to the new methodology. If an FS/NF-B does not comply with this requirement by **April 3, 2006**, CDHS will not have the necessary data to calculate several pass-through components of the reimbursement rate. The lack of supplemental schedule data will limit CDHS from fully identifying certain costs that AB 1629 legislation mandates to be reimbursed in cost groupings with higher reimbursement ceilings.

Facilities that do not submit the *Administration Costs Supplemental Schedule* by **April 3, 2006** will remain at the costs shown on their fiscal period end 2004 OSHPD Report and will be subject to lower reimbursement ceilings for the administrative cost category.

Facilities that do not submit the *Indirect Care Services Supplemental Schedule* by **April 3, 2006** will be subject to a reduction for calculating this portion of the labor cost category.

Questions regarding the supplemental schedules can be sent via e-mail to **supp1629@dhs.ca.gov** or by leaving a voice mail message at (916) 552-8613.

Multiple Modifiers Added to eTAR

Beginning February 20, 2006, providers can enter multiple modifiers for a single service code to the electronic Treatment Authorization Request (eTAR).

Service Information

* **Service Code** (CPT or HCPCS Code) **Modifiers** (if applicable)

Service Description (40 characters accepted)

Not all services use multiple modifiers. If applicable, in addition to using the -RT or -LT modifiers, providers will use the "Side" dropdown field to select Right, Left or Bilateral for all services that required this selection prior to the change. "Side" should not be confused with modifiers -RT or -LT. A list of services for which multiple modifiers are applicable can be found in the "Transaction Services" area of the Medi-Cal Web site at **www.medi-cal.ca.gov**.

For more information about eTAR transactions, please access the online eTAR tutorials by clicking the "Education & Outreach" link on the Medi-Cal home page.

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Remove and replace:	rate facil 7 rate facil diem 1/2
Remove and replace At the end of the *TAR Criteria For* *DP/NF Authorization* section:	*Family Certification* and *Medical Certification* forms *****

* Pages updated due to ongoing provider manual revisions.