MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Long Term Care

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Contents

HCBS Billing Changes

Waiver Updates
Effective for dates of service on or after November 1, 2006, in compliance with HIPAA, the California Department of Health Services will allow only HCPCS Level II codes and modifiers when billing for the Home and Community-Based Services (HCBS) waiver program. HCPCS Level III codes and modifiers will no longer be reimbursable by Medi-Cal. More information will be available in future *Medi-Cal Updates*.

Note: For HCBS waiver services that have been previously authorized, HCPCS Level III codes and modifiers will be paid for dates of service up to May 31, 2007.

For more information, in-state providers may call the Telephone Service Center at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200.

Code and Rate Correlation Table Changes
The rate for procedure code T1005 (Respite care services, up to 15 minutes) for Personal Care Agency and Employment Agency provider types has changed to $3.62 per unit.

Supplemental Schedules Required for AB 1629 Rate Methodology

AB 1629 requires the California Department of Health Services (CDHS) to 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(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. For the August 1, 2007 rates, supplemental schedules are due to CDHS by January 31, 2007.

The W&I Code identifies the following five cost categories for setting facility-specific rates:

1. Labor
2. Indirect care non-labor
3. Administrative
4. Capital costs
5. Direct pass-through costs

W&I Code, Section 14126.027(c), authorizes CDHS to use *Medi-Cal Updates* for notifying providers about implementation of the cost-based, facility-specific rate methodology.

See **Supplemental Schedules**, *page 2*

Supplemental Schedules *(continued)*

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**.

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 voluntary supplemental schedule will be available to download at **www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**.

Supplemental Schedules Reporting Period
For the rate year beginning August 1, 2007, 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 2005. 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 2005. 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 2005, 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 is required.)
It is critical that supplemental schedules be submitted to CDHS in a standardized electronic format and in a timely manner. Please download the supplemental schedules in the prescribed Excel format from the CDHS Long-Term Care System Development AB 1629 Web page (**www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**). Submit completed versions of the electronic supplemental schedules to the CDHS via an e-mail address created specifically for these documents – **supp1629@dhs.ca.gov**. Please view **http://alirts.oshpd.ca.gov/AdvSearch.aspx** and label the electronic file according to the posted instructions for the supplemental schedules on the Web site. If electronic download and submission is not available, please contact (916) 552-8613 for further instructions about transmitting this data.

Due Date – January 31, 2007
All supplemental schedules are due to CDHS by January 31, 2007. 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 January 31, 2007, 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 January 31, 2007 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 January 31, 2007 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.

Long Term Care Reimbursement Rates Update

Effective for services provided on or after August 1, 2006, unless otherwise noted, reimbursement rates for the following Long Term Care (LTC) facilities have changed:

- Nursing Facilities Level A (NF-A) and Level B (NF-B)
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Intermediate Care Facilities for the Developmentally Disabled/Habilitative (ICF/DD/H)
- Intermediate Care Facilities for the Developmentally Disabled/Nursing (ICF/DD/N)
- Unlimited swing beds
- Distinct-Part subacute care, including pediatric subacute care

Nursing Facility Level A
Effective August 2, 2003, the NF-A per diem rate no longer uses 100+ beds to establish rates. Rates are set solely by geographical location. NF-A facilities with licensed bed capacities of 100+ that receive a rate of $89.54 effective August 1, 2002, will continue to receive this rate until their prospective county rate reaches this level.

Distinct-Part Nursing Facilities (DP/NF)
The reimbursement to hospitals with DP/NFs is the lesser of projected costs or the maximum reimbursement of $310.68. Facilities below the maximum rate have facility-specific rates, subject to change. The California Department of Health Services (CDHS) will notify providers in a separate letter of facility-specific rates.

Distinct-Part Subacute Facilities (including pediatric subacute care)
Subacute providers are reimbursed the lesser of their projected costs or the maximum reimbursement rate for each category of reimbursement. CDHS will notify providers in a separate letter about facility-specific rates.

Claims reimbursed at the previous rate for services rendered on or after August 1, 2006 will be reprocessed.

The updated information is reflected on manual replacement pages rate facil diem 1 thru 7 (Part 2).

Updated Facility-Specific Reimbursement Rates

For dates of service on or after August 1, 2006, facility-specific provider reimbursement rates for Free-Standing Nursing Facilities Level B (FS/NF-B) and Free-Standing Subacute Nursing Facilities Level B (FSSA/NF-B) are updated.

Providers need not take action. Claims paid at the prior rate for services rendered on or after August 1, 2006 will be reprocessed for retroactive rate adjustments.

The facility-specific rates are on the California Department of Health Services Web site (**www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**). Providers must use the new rates to bill for services on or after August 1, 2006. Out-of-state or border providers will be reimbursed at the statewide weighted average of $148.59.

Facility-specific reimbursement rates are computed on an annual basis. Therefore, rates effective on or after August 1, 2006 are based upon the as-submitted Office of Statewide Health Planning and Development (OSHPD) Disclosure Reports with fiscal end dates in 2004. Reimbursement rates effective for dates of service on or after August 1, 2007 will be based on the as-submitted OSHPD Disclosure Reports with fiscal end dates in 2005.

The updated information is reflected on manual replacement page rate facil diem 2 (Part 2).

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: forms leg 3/4 *
forms reo ltc 1/2 *
rate facil diem 1 thru 7

* Pages updated due to ongoing provider manual revisions.