# Table of Contents

**State/Territory Name: California**

**State Plan Amendment (SPA) #: 15-025**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

**Financial Management Group**

DEC 09 2015

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: California State Plan Amendment 15-025

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 15-025. This amendment removes references to the Transitional Inpatient Care (TIC) program, which ended in 2003, effective July 1, 2015.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment TN 15-025 is approved effective July 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Blake Holt at (415) 744-3754.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: **15-025**

2. STATE: **California**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
n/a

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $ 0
b. FFY 2016 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Limitations on Attachment 3-1-A, Pages 1.1 – 1.4, 8.6~~
~~Limitations on Attachment 3-1-B, Pages 1.1 – 1.4, 8.6~~
Attachment 4.19-D, Pages ~~1,~~ 2, 3, 4, 5, 9, 10, Table 1
~~Attachment 4.19-D, Supplement 3, Pages 1-3~~
~~Attachment 4.19-D, Appendix 4, Pages 1-3~~ Attachment 4.19-D, Supplement 4, Page 2
Attachment 4.19-A, Pages 3, 30-32; Appendix 2, Page 21B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Limitations on Attachment 3-1-A, Pages 1.1 – 1.4, 8.6
Limitations on Attachment 3-1-B, Pages 1.1 – 1.4, 8.6
Attachment 4.19-D, Pages ~~1,~~ 2, 3, 4, 5, 9, 10, Table 1
Attachment 4.19-D, Supplement 3, Pages 1-3
Attachment 4.19-D, Appendix 4, Pages 1-3
Attachment 4.19-A, Pages 3, 30-32; Appendix 2, Page 21B
Attachment 4.19-D, Supplement 4, Page 2

10. SUBJECT OF AMENDMENT:
Remove references of the Transitional Inpatient Care Program

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

ORIGINAL SIGNED

12. TYPED NAME:
**Mari Cantwell**

13. TITLE:
**Deputy Director**
**Health Care Programs**
**State Medicaid Director**

14. DATE SUBMITTED: SEP 30 2015

16. RETURN TO:

**Department of Health Care Services**
**Attn: State Plan Coordinator**
**1501 Capitol Avenue, MS 4506**
**P.O. Box 997413**
**Sacramento, CA 95899-7413**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: DEC 09 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMG

23. REMARKS:
Attachment 4.19D Page 1 deleted by CA in Boxes 8 and 9. Other changes in Box 8 by CMS with state concurrence.

FORM HCFA-179 (07-92)

E. Reimbursement for hospital inpatient services provided by State Hospitals under the jurisdiction of the State Department of Developmental Services and State Hospitals will be exempt from Section 1 through XVI of this Plan. Payment for services to these providers will be under Medicare retrospective reimbursement principles; audit, administrative and appeal procedures; and applicable cost ceiling limitations.

F. Each provider shall be notified of the ARPDL and PGRPDL at the time of tentative and/or final PIRL settlements. If only a final PIRL settlement is issued, it shall take the place of both the tentative and final PIRL settlement.

G. Payments for Medicare covered services provided to Medicare/Medi-Cal crossover patients shall not be subject to the limitations specified in this part of the Plan. These services shall be reimbursed only for the Medicare deductibles and co-insurance amounts. The deductibles and co-insurance amounts shall not exceed the state reimbursement maximums. State reimbursement maximums shall be the interim rate times Medi-Cal charges after consideration of the Medicare payment.

H. Payment for skilled nursing facility services shall be made in accordance with Section 51511.

I. Payment for intermediate care facility services shall be made in accordance with Section 51510.

J. [Intentionally Left Blank]

K. [Intentionally Left Blank]

## METHODS AND ASSUMPTIONS FOR DEFINING DISPROPORTIONATE SHARE HOSPITALS

A. Final Determination

The annual determination of disproportionate share status as shown on the disproportionate share list will be final (no retroactive changes will be made based on actual year of service data).

The following describes the determination, data, and the processes to be used in determining a hospital's status as a disproportionate share provider and the applicable payment adjustments.

All calculations are to be rounded to the nearest tenth of a percent.

B. Medicaid Inpatient Utilization Rate

(1) Individual Hospital Calculation

A hospital's Medicaid inpatient utilization rate shall be the quotient (expressed as a percentage) which results from dividing the number of the hospital's acute care inpatient days attributable to patients who (for such days) were eligible for medical assistance under this State Plan during a defined 12-month period by the total number of the hospital's inpatient days during the same time period. In calculations involving Medicaid Inpatient Utilization Rates, this period is the most recent calendar year ending 18 months prior to the beginning of the payment adjustment year in question. For example, if disproportionality were being determined for the 1991-92 payment adjustment year, the defined period would be calendar year 1989.

To determine "Medicaid Days" the State shall total for each hospital the general acute care inpatient days, all nursery inpatient days, acute psychiatric inpatient days, and administrative days for the calendar year ending 18 months prior to the beginning of the payment adjustment year for which payment adjustments are required. These data are based on the Medi-Cal Month of Payment tapes created by the State's fiscal intermediary and

transmitted by the intermediary to the Department of Health Care Services. The acute psychiatric inpatient days provided to Medicaid eligible persons under the Short - Doyle/Medi- Cal program are taken from a separate file of the Medi- Cal Paid Claims System for the same calendar year. General acute care inpatient and acute psychiatric care inpatient days for Medicaid eligible persons paid by Health Insuring Organizations (HIO) are included in the calculations. When consistent and reliable data is available statewide as determined by the Department of Health Care Services, the Department may include general acute care inpatient and acute psychiatric care inpatient hospital days attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department to provide such services. Using the OSHPD statewide data base file for the calendar year ending 18 months prior to the beginning of the payment adjustment year for which payment adjustments are required, the number of Medicaid patient days for non-California Medicaid beneficiaries reported by each hospital is divided by the total number of Medicaid patient days reported by each hospital. The count of Medicaid patient days is based on discharge records which report that Medi- Cal (used synonymously with Title XIX) was the expected principal source of payment at the time of discharge. Acute care, psychiatric and rehabilitation care types of discharge records are included, while skilled nursing, intermediate care and non-acute alcohol/drug rehabilitation care discharge records are excluded from the calculation of the ratio. This ratio is then applied to each hospital's paid Medi-Cal days for the same period to estimate those Medicaid days which originate outside of the state. (It is noted that "Medicaid Days" does not include subacute care days and long term care days.)

To determine "Total Days" the State shall use data from the OSHPD statewide data base file for the calendar year ending 18 months prior to the beginning of the particular payment adjustment year. In calculating the actual number of "Total Days," the State shall add the general acute care inpatient days, all nursery inpatient days, acute psychiatric inpatient days, and administrative days in the Annual Report and shall subtract the patient days

for chemical dependency recovery services in licensed general acute patient beds and in licensed acute psychiatric care beds in the Annual report.

The specific formulae used to derive this percentage are as follows:

MEDICAID_ PERCENT = ((MEDICAID_DAYS/TOTAL_DAYS) *100)

WHERE:

MEDICAID DAYS = Total Paid Medicaid Days +
Est. Out of State Medicaid Patient Days

Total Paid Medicaid Days =
Medicaid GAC Days + Medicaid APC Days +
Medicaid-Nursery Days +
Medicaid-Short Doyle Days +
Medicaid Administrative Days

Estimated Out of State Medicaid Beneficiary Patient Days =
(Total Paid Medicaid Days *
(Out of State Medicaid Beneficiary Patient Days
/Total Medicaid Patient Days))

Total Medicaid Patient Days and
Out of State Medicaid Beneficiary Patient Days
are extracted directly from the OSHPD Discharge
Data Set and are as reported by the hospital.

TOTAL DAYS = Total GAC Days + Total APC Days +
Total Nursery Days +
Chem Dependency Days in GAC Beds -
Chem Dependency Days in APC Beds

GAC = General Acute Care
APC = Acute Psychiatric Care

The following arithmetic symbols are used:

+ addition
- (dash) subtraction
* multiplication
/ division

In addition, the symbol (underscore) is used to connect words that are part of variable names.

28. [Intentionally Left Blank]

29. "Public hospital" means a hospital that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

30. "Nonpublic hospital" means a hospital that satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; does not meet the definition of a nonpublic/converted hospital as described in subsection 31; and does not meet the definition of a converted hospital as described in subsection 32.

31. "Nonpublic/converted hospital" means a hospital that satisfies all of the following, or, if two or more inpatient facilities are licensed by the Department under a consolidated license, a hospital as to which any component of the hospital satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; at any time during the 1994-95 payment adjustment year, was a public hospital as described in subsection 29 (whether or not the hospital or such component currently is located at the same site as it was located when it was a public hospital); and does not meet the definition of a converted hospital as described in subsection 32.

32. "Converted hospital" means a hospital that satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; and at any time during the 1999-2000 payment adjustment year, was an eligible hospital meeting the definition of a public hospital as described in subsection 29 (whether or not the hospital currently is located at the same site as it was located when it was a public hospital).

33. "Remained in operation" or "remains in operation" means that, except for closure or other cessation of services caused by natural disasters or other events beyond that hospital's reasonable control (including labor disputes), the hospital was licensed to provide hospital inpatient services, and continued to provide, or was available to provide, hospital inpatient services to Medi-Cal patients throughout the particular time period in question.

subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are:

1. Allied health services ordered by the attending physician, excluding respiratory therapy.
2. Alternating pressure mattresses/pads with motor.
3. Atmospheric oxygen concentrators and enrichers and accessories.
4. Blood, plasma and substitutes.
5. Dental services.
6. Durable medical equipment as specified in Section 51321(g).
7. Insulin.
8. Intermittent positive pressure breathing equipment.
9. Intravenous trays, tubing and blood infusion sets.
10. Laboratory services.
11. Legend drugs.
12. Liquid oxygen system.
13. MacLaren or Pogon Buggy.
14. Medical supplies.
15. Nasal cannula.
16. Osteogenesis stimulator device.
17. Oxygen (except emergency).
18. Parts and labor for repairs of durable medical equipment if originally separately payable or owned by beneficiary.
19. Physician services.
20. Portable aspirator.
21. Portable gas oxygen system and accessories.
22. Precontoured structures (VASCO-PASS, cut out foam).
23. Prescribed prosthetic and orthotic devices for exclusive use of patient.
24. Reagent testing sets.
25. Therapeutic aid fluid support system/beds.
26. Traction equipment and accessories.
27. Variable height beds.
28. X-rays.

For subacute and pediatric subacute levels of care, items can be separately billed as specified in Title 22 CCR, Sections 51511.5(d) and 51511.6(f), respectively, as those sections read as of July 1, 2015.

E. The application of the methodology described in this Attachment, with the most recent update factors and constants used to project costs, is included in an annual rate study conducted by the Department prior to August 1st each year and required by the CCR as an evidentiary base for the filing of new and/or revised regulations. This annual rate study is designated as Supplement 1, and will be provided to the Centers for Medicare and Medicaid Services (CMS) by December 31st of the rate year. The rates will become effective as provided for by the State's Budget Act, typically on August 1 of each year.

F. If a freestanding facility's change in bedsize has an impact on the reimbursement rate, the lesser of the existing rate or the new rate shall prevail until the next general rate change. This is to deter a facility from changing bedsize groupings for the purpose of maximizing reimbursement.

G. Notwithstanding any other provisions of this State Plan, the reimbursement rate shall be limited to the usual charges made to the general public, not to exceed the maximum reimbursement rates set forth by this Plan.

H. Within the provisions of this Plan, the following abbreviations shall apply: NF- nursing facility; ICC/DD-intermediate care facility for the developmentally disabled; ICF/DD-H-intermediate care facility for the developmentally disabled habilitative; ICF/DD-N-intermediate care facility for the developmentally disabled nursing; STP- special treatment program; and DP-distinct part.

I. All long term care providers shall be required to be certified as qualified to participate in the Medi-Cal program and must also meet the requirements of Section 1919 of the Social Security Act. In order to assure that reimbursement takes into account the cost of compliance with statutory requirements, NFs shall be reimbursed based on the following criteria: (Refer to Table 1 for a specific list)

1. Resident acuity:

NFs shall be reimbursed based on the provision of the following services: level A; level B; subacute – ventilator and non-ventilator dependent; and pediatric subacute -- ventilator and non-ventilator dependent. Level A services are provided to a NF resident who requires medically necessary services of relatively low intensity. Level B, subacute and pediatric subacute

services are provided to a NF resident who requires medically necessary services of varying degrees of higher intensity. The criteria for the acuity of NF services and staffing standards are contained in state regulations and policy manuals.

2. Organization type:

   (a) Freestanding facilities.
   (b) DP/NFs - A distinct part nursing facility is defined as any nursing facility (level A or B) which is licensed together with an acute care hospital.
   (c) Swing-beds in rural acute care facilities.
   (d) Subacute units of freestanding or distinct part NFs - A subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).
   (e) Pediatric subacute units of freestanding or distinct part NFs - A pediatric subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).

3. Bedsize:

   As listed below, in determining the appropriate bedsize categories for reimbursement purposes, a facility's total number of beds shall be used, irrespective of patient acuity level or licensure. A single facility licensed as a distinct part to provide two or more patient acuity levels, or a single facility that has separate licenses for different patient acuity levels, shall have the bedsize for each patient acuity level determined by total beds within the actual physical plant. The bedsize used to establish rates shall be based upon the data contained in the cost report(s) included in the rate study.

   (a) NF level B...1-59, and 60+
   (b) DP/NF level B...no bedsize category
   (c) NF level B/subacute ...no bedsize category
   (d) DP/NF level B/subacute ...no bedsize category
   (e) NF level B/pediatric subacute...no bedsize category

(f) DP/NP level B/pediatric subacute ... no bedsize category
(g) NF level A ... no bedsize category
(h) DP/NF level A ... no bedsize category
(i) ICF/DD ... 1-59, 60+ and 60+ with a distinct part
(j) ICF/DD-H ... 4-6 and 7-15
(k) ICF/DD-N ... 4-6 and 7-15
(l) Swing-beds ... no bedsize category

4. Geographical location:

(a) Freestanding NF levels A and B and DP/NF level A:
(1) Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, and Sonoma counties.
(2) Los Angeles county.
(3) All other counties.
(b) DP/NF level B, freestanding NF level B/subacute and pediatric subacute, DP/NF level B/subacute and pediatric subacute, ICF/DDs, ICF/DD-Hs, and ICF/DD-Ns, ... statewide.
(c) Rural swing-beds ... statewide.

J. Special Treatment Program (STP)

For eligible Medi-Cal patients 65 years or older who receive services in an Institution for Mental Disease the STP patch rate will apply. This is flat add-on rate determined to be the additional cost for facilities to perform these services. STP does not constitute a separate level of care.

II. COST REPORTING

A. All long term-care facilities participating in the Medi-Cal Program shall maintain, according to generally accepted accounting principles, the uniform accounting system's adopted by the State and shall submit cost reports in the manner approved by the State.

1. Cost Reports are due to the State no later than 120 days after the close of each facility's fiscal year (150 days for facilities that are distinct parts of a hospital), in accordance with Medicare and Medi-Cal cost reporting

(e) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(i) Addressing a grievance or negotiating or administering a collective bargaining agreement.

(ii) Allowing a labor organization or its representatives access to the provider's facilities or property.

(iii) Performing an activity required by federal or state law or by a collective bargaining agreement.

(iv) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

III. AUDITS

A. Except for DP/NFs, subacute, pediatric subacute, NF-As, ICF/DDs and state-operated facilities, a minimum of 15 percent of cost reports will be field audited by the Department each year. Facilities identified for audit shall be selected on a random sample basis, except where the entire universe of a class is selected for audit. Field audits may be restricted to facilities that have a complete year of reporting. The sample size for each shall be sufficiently large to reasonably expect, with 90 percent confidence, that it will produce a sample audit ratio which varies from the estimated class population audit ratio by not more than two percent. Other facilities may be audited as necessary to ensure program integrity. The results of federal audits, where reported to the State, may also be applied in determining the audit adjustment for the ongoing rate study.

B. The labor data reported by providers shall be audited. In the event that facilities are inconsistently reporting their labor costs in the OSHPD data, the Department will adjust the data utilized to develop the labor index so that the correct amount will be reflected. If the labor data used in developing the labor index is adjusted, the State Plan will be amended to provide the specific methodology for such adjustments.

C. Reports of audits shall be retained by the State for a period of not less than three years, in accordance with 42 CFR 433.32. Reports shall be retained beyond three years if audit findings have not been resolved.

D. Providers will have the right to appeal findings which result in an adjustment to program reimbursement or reimbursement rates. Specific appeal procedures are contained in Section 14171 of the Welfare and

Institutions Code, and Article 1.5 (Provider Audit Appeals) of Title 22, California Code of Regulations. See Appendix 2.

E. When facilities being audited have more than one cost report with an end date in the audit year, the last report will be the one audited, except in those cases where a facility-specific audit adjustment will be applied or actual audited costs are used. In these cases, all cost reports with an end date in the audit year will be audited.

F. All state-operated facilities will be subject to annual audits.

G. Cost reports for nursing facilities that are distinct parts of acute care hospitals may be audited annually.

H. All subacute and pediatric subacute providers will be subject to annual audits.

## IV. PRIMARY REIMBURSEMENT RATE METHODOLOGY

Reimbursement rates shall be reviewed by the Department at least annually. Prospective rates for each class shall be developed on the basis of cost reports submitted by facilities. The following method shall be used to determine rates of reimbursement for a class of facilities when cost reports are available:

A. Audit Adjustment.

1. An audit adjustment shall be determined for each of the following classes:

   (a) NF level B field audited facilities with 1-59 beds.
   (b) NF level A field audited facilities with no bedsize category.
   (c) NF level B field audited facilities with 60+ beds.
   (d) ICF/DD field audited facilities with 1-59 beds.
   (e) ICF/DD field audited facilities with 60+ beds.
   (f) ICF/DD-H field audited facilities with combined bedsizes.
   (g) ICF/DD-N field audited facilities with combined bedsizes.

2. Except for DP/NFs and subacute providers, where the audit sample exceeds 80 percent of the universe in a class, the audit adjustment will be applied on a facility-specific basis except that the: (1) class average will be used for unaudited facilities and (2) actual audited costs will be used when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study.

*LONG TERM CARE (LTC) CLASSES TO BE USED FOR RATE-SETTING PURPOSES*

| *PATIENT ACUITY LEVELS* | *ORGANIZATION TYPE* | *No. of Beds* | *Geographical Location* | *Reimbursement Basis* |
|---|---|---|---|---|
| NF LEVEL B | -Distinct part NF | All | Statewide | * |
| | -Freestanding NF | 1-59 | Los Angeles Co. | Median |
| | | 1-59 | Bay Area** | Median |
| (EXCEPT SUBACUTE AND PEDIATRIC SUBACUTE.) | | 1-59 | All Other Counties | Median |
| | | 60+ | Los Angeles Co. | Median |
| | | 60+ | Bay Area** | Median |
| | | 60+ | All Other Counties | Median |
| SUBACUTE: | | | | |
| VENTILATOR DEPENDENT | -Distinct part NF | All | Statewide | * |
| | -Freestanding NF | All | Statewide | * |
| NON-VENTILATOR DEPENDENT | -Distinct part NF | All | Statewide | * |
| | -Freestanding NF | All | Statewide | * |
| PEDIATRIC SUBACUTE: | | | | |
| VENTILATOR DEPENDENT | -Distinct part NF | All | Statewide | Model |
| | -Freestanding NF | All | Statewide | Model |
| NON-VENTILATOR DEPENDENT | -Distinct part NF | All | Statewide | Model |
| | -Freestanding NF | All | Statewide | Model |
| NF LEVEL A | -All | All | Los Angeles Co. | Median |
| | | All | Bay Area** | Median |
| | | All | All Other Counties | Median |
| ICF/DD | -All | 1-59 | Statewide | 65th percentile |
| | | 60+ | Statewide | 65th percentile |
| ICF/DD-Hs and Ns | -All | 4-6 | Statewide | 65th percentile |
| | | 7-15 | Statewide | 65th percentile |
| RURAL SWING-BED NF LEVEL B SERVICES | -Rural acute hospitals | All | Statewide | Median |

*DP/NF level Bs and Subacute providers are reimbursed at either the lesser of costs as projected by the Department or the prospective median rate of the LTC class.
**Bay area is defined as San Francisco, San Mateo, Marin, Napa, Alameda, Santa Clara, Contra Costa, and Sonoma counties.
***Current rate increased by the same percentage rate as received by other NF level A's.

II. General Provisions

A. Within the provisions of this Supplement, the following abbreviation will apply: FS/NF-B meaning freestanding level-B nursing facility.

B. Reimbursement to FS/NF-Bs (excluding those with FS/NF-B subacute beds) will be for routine per diem services, exclusive of ancillary services. The reimbursement rate for these ancillary services are reviewed and audited by the Department and are reimbursed separately.

C. The routine service per diem reimbursement rate will be consistent with Medicare Reimbursement Principles as specified in Title 42, Code of Federal Regulations, Part 413. Aggregate Medi-Cal payments may not exceed the aggregate payments that the state would pay for the same or similar services under the Medicare Prospective Payment System.

D. The FS/NF-B routine service per diem payment includes all equipment, supplies and services necessary to provide appropriate nursing care to long-term care residents, except those items listed as separately payable, as described in the California Code of Regulations, Title 22, section 51511(c), as that section reads as of July 1, 2015, or personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility and periodic haircuts performed as part of resident care), and television rental.

E. For subacute care units of FS/NF-Bs the per diem payment includes all services, equipment and supplies necessary for the administration of the treatment procedures for residents determined to need subacute care services. Items included in the reimbursement rate are specified in the California Code of Regulations, Title 22, section 51511.5(d), as that section reads as of July 1, 2015.

F. Notwithstanding any other provisions of this State Plan, the per diem payment will be limited to the usual charges made to the general public, as described in the California Code of Regulations, Title 22, section 51501, as that section reads as of July 1, 2015.

G. All long-term care providers must be licensed and certified to participate in the Medi-Cal program and must meet the requirements of the California Code of Regulations, Title 22, section 51200, as that section reads as of July 1, 2015. In order to ensure that reimbursement rates take into account the cost of compliance with statutory requirements, FS/NF-Bs will be reimbursed according to this Supplement based on the following resident acuity levels:

1. Freestanding NF-B residents;
2. Freestanding subacute ventilator-dependent residents;
3. Freestanding subacute non-ventilator-dependent residents.