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State/Territory Name: California

State Plan Amendment (SPA) #: 20-0023

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

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

Financial Management Group

September 7, 2021

Jacey K. Cooper
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 Transmittal Number 20-0023

Dear Ms. Cooper:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 20-0023. Effective August 1, 2020, this amendment renews and modifies the facility-specific rate setting methodology for freestanding skilled nursing facilities and subacute care units of freestanding skilled nursing facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) 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 20-0023 is approved effective August 1, 2020. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Mark Wong at (415) 744-3561 or mark.wong@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Acting Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 0 — 0 0 23

2. STATE: California

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: August 1, 2020

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: Title 42 § CFR 447 Subpart B & C

7. FEDERAL BUDGET IMPACT
a. FFY 19/20 $ 458,199 (in thousands)
b. FFY 20/21 $2,821,362 ~~$ 2,845,418~~ (in thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D – Page 1, Table 1
Supplement 4 to Attachment 4.19 D – pages 1, 4, 6-10, 14-17, 17a, 18-19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D – Page 1, Table 1
Supplement 4 to Attachment 4.19 D – pages 1, 4, 6-10, 14-19

10. SUBJECT OF AMENDMENT

Continue and amend the rate setting methodology for Skilled Nursing Facilities (Level-B) and Freestanding Adult Subacute Facilities, effective August 1, 2020 through December 31, 2021.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Jacey Cooper

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: September 10, 2020

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 10, 2020

18. DATE APPROVED: September 7, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: August 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted] For

21. TYPED NAME: Rory Howe

22. TITLE: Acting Director, Financial Management Group

23. REMARKS

For Box 11 "Other, As Specified," please note: The Governor's Office does not wish to review the State Plan Amendment.

Pen-and-ink change made to Box 7 by CMS with state concurrence.

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

The purpose of this State Plan is to (1) establish the principles of the State of California's reimbursement system for providers of long-term care services to assure compliance with the requirements of Title XIX of the Federal Social Security Act and the Code of Federal Regulations, and (2) describe the procedures to be followed by the single State agency, the Department of Health Services (herein called the Department), in determining long-term care reimbursement rates.

Beginning with the 2005/06 rate year, the reimbursement rate methodology applicable to long-term care freestanding nursing facilities level-B and subacute facilities is described in Supplement 4 to Attachment 4.19-D. Assembly Bill (AB) 1629 (Statutes 2004, Chapter 875) mandates a facility-specific reimbursement methodology to be effective on August 1, 2005. Subsequent legislation extended the current rate methodology established by AB 1629. Pursuant to AB 119 (Statutes 2015, Chapter 17), the rate methodology was extended to July 31, 2020. Pursuant to Assembly Bill (AB) 81 (Chapter 13, Statutes of 2020) the rate methodology was amended and extended to December 31, 2022.

I. GENERAL PROVISIONS

A. The State shall set prospective rates for services by various classes of facilities, including special programs.

B. Reimbursement shall be for routine per diem services, exclusive of ancillary services, except for state-owned facilities where an ancillary per diem rate shall be developed by another State agency, and for county facilities operating under a special agreement with the Department. These ancillary rates are reviewed and audited by the Department and, together with the routine service per diem, form an all-inclusive rate. The routine service per diem shall be based on Medicare principles of reimbursement. Ancillary services for all other facilities are reimbursed separately on a fee for service basis as defined in the California Code of Regulations (CCR), except for facilities providing subacute and pediatric subacute care.

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 (EXCEPT ADULT SUBACUTE AND PEDIATRIC SUBACUTE)	-Distinct Part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	***
ADULT 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.

***Facility specific rate as determined by the methodology described in Supplement 4 to Attachment 4.19-D.

METHODS AND STANDARDS FOR ESTABLISHING FACILITY-SPECIFIC REIMBURSEMENT RATES FOR FREESTANDING SKILLED NURSING FACILITIES LEVEL-B AND SUBACUTE CARE UNITS OF FREESTANDING SKILLED NURSING FACILITIES

I. Introduction

A. This document, labeled Supplement 4 to Attachment 4.19-D, describes the overall reimbursement rate methodology for skilled nursing facility services provided to Medi-Cal recipients by: freestanding skilled nursing facilities level-B (FS/NF-B), both publicly and privately operated, and (2) subacute care units of FS/NF-Bs as defined in California Code of Regulations, title 22, section 51124.5.

B. This Supplement is submitted by the single State Medicaid (Medi-Cal) Agency, the State of California Department of Health Services (hereinafter "Department"). This Supplement is necessary to describe changes to the FS/NF-B reimbursement rate methodology adopted by the 2004 State Legislature in Assembly Bill (AB) 1629, signed into law on September 29, 2004, as Chapter 875 of the Statutes of 2004.

C. AB 1629 establishes the Medi-Cal Long-Term Care Reimbursement Act, which mandates a facility- specific rate-setting methodology effective on August 1, 2005; and which will cease to be operative on and after July 31, 2008. This statute requires the Department to develop and implement a Medi-Cal cost-based facility-specific reimbursement rate methodology for Medi-Cal participating FS/NF-Bs, including FS/NF-Bs with subacute care beds. AB 203, signed into law on August 24, 2007, as Chapter 188 of the Statutes of 2007, extends the operative date to July 31, 2009. AB 1183, signed into law on September 30, 2008, as Chapter 758 of the Statutes of 2008, extends the operative date to July 31,201 I.SB 853, signed into law on October 19, 2010, as Chapter 717 of the Statutes of 2010, extends the operative date to July 31, 2012. ABX 119, signed into law on June 28, 2011, as Chapter 4 of the Statutes of 2011, extends the operative date to July 31, 2013. AB 1489, signed into law on September 27, 2012, as Chapter 631 of the Statutes of 2012, extends the operative date to July 31, 2015. AB 119 (Chapter 17, Statutes of 2015) extends the operative date to July 31, 2020. Assembly Bill 81 (Chapter 13, Statutes of 2020) extends the operative date to December 31, 2022, and directs the department to make various revisions to the methodology.

D. The cost-based reimbursement rate methodology is intended to reflect the costs and staffing levels associated with the quality of care for residents in FS/NF-Bs. This methodology will be effective August 1, 2005, and will be implemented the first day of the month following federal approval. A retroactive increase in reimbursement rates to August 1, 2005, to FS/NF-Bs will be provided in the event that federal approval occurs after the effective date of the methodology.

E. August 1, 2020 through December 31, 2020 shall be a rate period, effective August 1, 2020. Beginning January 1, 2021, the rate year shall be the calendar year.

F. The reimbursement rates established will be based on methods and standards described in Section V of this Supplement.

G. Provisions of this legislation require that the facility-specific reimbursement rates for rate years 2005/06 and 2006/07 will not be less than the rates developed based upon the methodology in effect as of July 31, 2005, as described in Attachment 4.19-D, Pages 1 through 22 of the State Plan, plus projected proportional costs for new state or federal mandates for the applicable rate years.

H. The Department reserves the right to exclude any cost report or supplemental schedule or portion thereof that it deems inaccurate, incomplete or unrepresentative.

I. FS/NF-Bs that no longer participate in the Medi-Cal program will be excluded from the rate-setting process.

J. For purposes of calculating reasonable compensation of facility administrators, the Department will adhere to the standards established under Chapter 9 of the Centers for Medicare & Medicaid Services Provider Reimbursement Manual (HIM 15), reproduced in full in Volume 2 at Paragraph 5577 of the Commerce Clearing House Medicare and Medicaid Guide. The Department will conduct its own compensation survey for calculating reasonable compensation for facility administrators. Based on the data collected from such surveys, the state will develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those FS/NF-Bs, and adjust the costs accordingly.

IV. Audits and Audit Adjustments

A. The Department will conduct financial audits of FS/NF-Bs participating in the Medi-Cal program a minimum of once every three years. These audits may be full-scope field audits, limited scope reviews, or desk reviews. Limited scope or desk reviews will be conducted at intervening periods, as necessary. All subacute care units of FS/NF-Bs will be subject to audit or review on an annual basis.

B. The Department will adjust or reclassify reported cost and statistical information submitted by the FS/NF-Bs for the purposes of calculating facility-specific Medi-Cal rates consistent with applicable requirements of this Supplement and as required by Title 42, Code of Federal Regulations, Part 413.

C. Audited or reviewed cost data and/or prospective audit adjustments will be used and/or applied to develop facility-specific reimbursement rates.

1. On an annual basis, the Department will use FS/NF-B cost reports, including supplemental reports as required by the Department, and the results of any state or federal audits to determine if there is any difference between the reported costs used to calculate a FS/NF-B's reimbursement rate and the FS/NF-B's audited expenditures in the rate period or rate year.

2. If the Department determines that there is a difference between reported costs used to calculate a FS/NF-B's reimbursement rate and the audited facility expenditures, the Department will adjust the FS/NF-B's

B. The prospective per diem payment for each FS/NF-B is computed on a per resident day basis. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, professional liability insurance costs are included as a major cost category. The per diem payment is comprised of the following major cost categories:

1. labor costs
2. indirect care non-labor costs
3. administrative costs
4. professional liability insurance costs
5. capital costs
6. direct pass-through costs.

Payment for FS/NF-Bs will be based on facility-specific cost-based reimbursement rates consisting of the major cost categories, and determined as described in the following Section V.C. of this Supplement.

C. Cost Categories. The facility-specific cost-based per diem payment for FS/NF-Bs is based on the sum of the projected costs of the major cost categories, each subject to ceilings described in this Section. Costs within a specific cost category may not be shifted to any other cost category. In addition, per diem payments will be subject to overall limitations described in Section VI of this Supplement.

1. The labor cost category is comprised of a direct resident care labor cost component and an indirect care labor cost component. These components are comprised of more specific elements described below:

    a. Direct resident care labor costs include salaries, wages, and benefits related to routine nursing services personnel, defined as nursing, social services, and activities personnel. Direct resident care labor costs include labor expenditures associated with a FS/NF-B's permanent direct care employees, as well as expenditures associated with temporary agency staffing.

        i. For the rate year beginning August 1, 2005, and for subsequent rate years, the direct resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal direct resident care labor cost per diems. FS/NF-B's will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

        ii. For the rate period beginning August 1, 2020, and for subsequent rate years, the direct resident care labor cost component will be limited to the 95th percentile of each facility's respective peer group, as described in Section VII of this Supplement. FS/NF-B's will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

iii. An inflation index, based on the Department's labor study, developed from the most recently available industry- specific historical wage data as reported to OSHPD by providers will be applied to the FS/NF-B's allowable direct resident care labor per diem costs. Each facility's direct resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

b. Indirect care labor costs include all labor costs related to staff supporting the delivery of resident care including housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance costs.

i. In-service education activities are defined as education conducted within the FS/NF-B for facility nursing personnel. Salaries, wages and payroll-related benefits of time spent in such classes by those instructing and administering the programs will be included as in-service education labor costs. If instructors do not work full-time in the in-service education program, only the cost of the portion of time they spend working in the in-service education program is allowable. In-service education does not include the cost of time spent by nursing personnel as students in such classes or costs of orientation for new employees. The costs of nursing in-service education supplies and outside lecturers will be reflected in the in- service education non-labor costs of the indirect care non-labor cost category.

ii. For the rate year beginning August 1, 2005, and for subsequent rate years, the indirect resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the facility's most recently available cost report, as adjusted for audit findings. Each facility's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each facility's peer-grouped allowable Medi-Cal indirect. Resident care labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

iii. For the rate period beginning August 1, 2020, and for subsequent rate years, the indirect resident care labor cost component will be limited to the 95th percentile of each facility's respective peer group, as described in Section VII of this Supplement. FS/NF-B's will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

iv. An inflation index, based on the Department's labor study, developed from the most recently available industry-specific historical wage data as reported to OSHPD by providers will be applied to the FS/NF-B's allowable indirect resident care labor per diem costs. Each facility's indirect resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate period or rate year.

2. Indirect care non-labor costs include the non-labor costs related to services supporting the delivery of resident care, including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education and plant operations and maintenance costs. These costs are limited to the 75th percentile of each facility's respective peer-group, as described in Section VII of this Supplement.

   a. For the rate year beginning August 1, 2005, and for subsequent rate periods or rate years, the indirect care non-labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal indirect care non-labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

   b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF B's allowable indirect care non-labor per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate period or rate year.

3. Administrative costs include allowable administrative and general expenses of operating the facility, including a FS/NF-B's allocated expenditures related to allowable home office costs. The administrative cost category will include allowable property insurance costs, and exclude expenditures associated with caregiver training, liability insurance, facility license fees, and medical records. For the rate year beginning August 1, 2010, and subsequent rate periods or rate years, legal and consultant fees are excluded as stated below.

    a. For the rate year beginning August 1, 2005, and for subsequent rate periods or rate years, the administrative per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer- grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 50th percentile of the allowable Medi-Cal administrative cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

    b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF-B's allowable administrative per diem costs to inflate costs from the mid-point of the cost reporting period to the mid- point of the rate period or rate year.

    c. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, the administrative cost category will exclude any legal or consultant fees in connection with a fair hearing or other litigation against or involving any government agency or department until all issues related to the fair hearing or litigation issues are ultimately decided or resolved in favor of the FS/NF-B's.

4. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, the professional liability per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer-grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of the allowable Medi-Cal cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount. FS/NF-Bs must report the insurance deductibles in a format and by the deadline determined by the Department, or the deductibles will be reimbursed at the 50th percentile in the administrative cost category.

5. Capital costs. For the rate year beginning August 1, 2005, and for subsequent rate periods or rate years, a Fair Rental Value System (FRVS) will be used to reimburse FS/NF-B's property (capital) costs. Under the FRVS, the Department reimburses a facility based on the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, rent or lease payments. The FRVS establishes a facility's value based on the age of the facility. For rate periods or rate years subsequent to 2005/06, additions and renovations (subject to a minimum per-bed limit) will be recognized by lowering the age of the facility. The facility's value will not be affected by sale or change of ownership. Capital costs, limited as specified below in Section V.C.4.e. of this Supplement, are derived from the FRVS parameters as follows:

   a. The initial age of each facility is determined as of the mid-point of the 2005/06 rate year, using each facility's original license date, year of construction, initial loan documentation, or similar documentation. For the 2005/06 rate year, all FS/NF-Bs with an original license date of February 1, 1976, or prior, will have five years subtracted from their facility age to compensate for any improvements, renovations or modifications that have occurred in the past. The age of each facility will be adjusted every rate period or rate year, to reflect the facility's age, as appropriate, up to a maximum age of 34 years.

   b. Beginning with the rate year of August 1, 2006, and for subsequent rate periods or rate years costs incurred for major capital improvements, modifications or renovations equal to or greater than $500 per bed on a total licensed-bed basis will be converted into an equivalent number of new beds, effectively lowering the age of the facility on a proportional basis. If a facility adds or replaces beds, these new beds will be averaged in with the age of the original beds, and the weighted average age of all beds will represent the facility's age. If a facility performs a major renovation or replacement project (defined as a project with capitalized cost equal to or greater than $500 per bed, on a total bed basis), the cost of the renovation project will be converted to an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility.

      i. Beginning in the 2018-19 rate year, if a facility is at the maximum depreciation age of 34 years, the weighted average age calculation for effective facility age after improvements will be based on a base facility age of 34 years rather than the actual facility age to determine the new effective facility age.

   c. The FRVS per diem calculation, subject to the limitations identified in Section V.C.4.e. of this Supplement, is calculated as follows:

e. The capital costs based on FRVS will be limited as follows:

i. For the 2005/06 rate year, the capital cost category for all FS/NF-Bs in the aggregate will not exceed the Department's estimate of FS/NF-B's capital reimbursement for the 2004/05 rate year, based on the methodology in effect as of July 31, 2005.

ii. Beginning with the rate year of August 1, 2006, and for subsequent rate periods or rate years, the maximum annual increase for the capital cost category for all FS/NF-Bs in the aggregate will not exceed eight percent of the prior rate year's FRVS aggregate payment.

iii. If the total capital cost category for all FS/NF-Bs in the aggregate for the 2005/06 rate year exceeds the value of the capital cost category for all FS/NF-Bs in the aggregate for the 2004/05 rate year, the Department will reduce the capital cost category for each and every FS/NF-B in equal proportion.

iv. If the capital cost category for all FS/NF-Bs in the aggregate, beginning with the rate year of August 1, 2006, and for subsequent rate periods or rate years exceeds eight percent of the prior rate year's cost category, the Department will reduce the capital FRVS cost category for each and every FS/NF-B in equal proportion.

v. For the 2018/19 and subsequent rate years, if the aggregate maximum annual increase for the capital cost category calculated without the application of Section 5(b)(i) on page 10 and Section 5(c)(i)(a) on page 11, is less than the aggregate maximum annual increase for the capital cost category applying Section 5(b)(i) and Section 5(c)(i)(a), the Department will reduce the capital FRVS cost category for all FS/NF-Bs by an equal proportion, so that the aggregate maximum annual increase for the capital cost category will be equal to the aggregate maximum annual increase without the application of Section 5(b)(i) and Section 5(c)(i)(a).

6. Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, the Medi-Cal portion of the skilled nursing facility quality assurance fee, and new state and federal mandates for the applicable rate year. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, liability insurance costs are excluded from the direct-pass-through cost category.

a. For the rate year beginning August l, 2005, and for subsequent rate periods or rate years, the Medi-Cal proportional share of the pass-through per diem costs will be calculated as the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report and/or supplemental schedule(s), as adjusted for audit findings.

b. Caregiver training costs are defined as a formal program of education that is organized to train students to enter a caregiver

occupational specialty. Eligible caregiver training costs include any and all trainings that enhance the skills, education, or career advancement for nursing facility workers. Until the Medi-Cal cost report is revised to specifically identify these costs, FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

c. The Medicare reimbursement principles consistent with Title 42, Code of Federal Regulations, Part 413 will be used to determine reasonable allowable pass through costs for professional liability insurance. FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, liability insurance costs are excluded from the direct pass-through cost category.

d. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to update caregiver training costs and liability insurance costs from the mid-point of the cost report period or supplemental report period to the mid-point of the rate year. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, liability insurance costs are excluded from the direct pass-through cost category.

e. Property tax pass-through costs will be updated at a rate of two percent annually from the mid-point of the cost report period to the mid-point of the rate period or rate year.

f. Facility-license fee pass-through costs and the Medi-Cal portion of the skilled nursing facility quality assurance fee will be applied on a prospective basis for each rate period or rate year, and will not require an inflation adjustment.

D. For the 2005/06 and 2006/07 rate years, the facility-specific Medi-Cal reimbursement rate calculated under the methodology set forth in Section V of this Supplement will not be less than the Medi-Cal reimbursement rate that the FS/NF-B would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005/06 and 2006/07, respectively.

E. Pursuant to AB 81, the details, definitions and formulas may be set forth in regulations and provider bulletins or similar instructions.

F. The Department will establish reimbursement rates pursuant to AB 81 on the basis of facility cost data reported in the Integrated Long-Term Care Disclosure and Medi-Cal Cost Report required by Health and Safety Code section 128730 for the most recent

reporting period available and cost data reported in other facility financial disclosure reports, supplemental reports, or surveys required by the Department.

G. The percentiles in labor costs, indirect care non-labor costs, and administrative costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis. For the rate year beginning August 1, 2010, and for subsequent rate periods or rate years, professional liability costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis.

VI. Limitations on the Medi-Cal Facility-Specific Reimbursement Rate Calculation

In addition to limitations described in Section V.C.4.e. of this Supplement (FRVS reimbursement limitations), the aggregate facility-specific Medi-Cal payments calculated in accordance with the methodology set forth in Section V of this Supplement will be limited by the following:

A. For the 2005/06 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed eight percent of the weighted·average reimbursement rate for the 2004/05 rate year, as adjusted for the change in the cost to the FS/NF-B to comply with the skilled nursing facility quality assurance fee for the 2005/06 rate year, plus the total projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

B. For the 2006/07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed five percent of the weighted average Medi-Cal rate for the 2005/06 rate year, as adjusted for the projected FS/NF-B Medi- Cal cost of complying with new state or federal mandates.

C. For the 2007/08 and 2008/09 rate years, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medi-Cal rate for the 2006/07 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

D. For the 2009/10 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not be increased over the weighted average Medi-Cal rate for the 2008-09 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

E. For the 2010/11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3.93 percent of the maximum annual increase in the weighted average rate from the 2009/10 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

F. For the 2011/12 rate year, the maximum annual increase of each FS/NF-Bs Medi-Cal reimbursement rate will not exceed 2.4 percent from the rate effective May 31, 2011, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

G. For services provided on and after June 1, 2011 through July 31, 2012, Medi-Cal payments will equally be reduced by 10 percent. Specifically, for the period June 1, 2011 through July 31, 2011, the payment is based on the 2010-11 rate that would otherwise be paid to each FS/NF-B, reduced by 10 percent. Accordingly, for the period August 1, 2011 through July 3l, 2012, the payment is based on the 2011-12 rate that otherwise would be paid to each FS/NF-B, reduced by 10 percent. The Department will determine the amount of reduced payments for each FS/NF-B, equivalent to the 10 percent payment reduction for the period beginning June 1, 2011, through July 31, 2012, and provide a supplemental payment to each FS/NF-B no later than December 31, 2012.

H. To the extent that the prospective facility-specific reimbursement rates are projected to exceed the adjusted limits calculated pursuant to VI.A, VI.B, VI.C, VI.D, VI.E, and VI.F of this Supplement, the Department will adjust the increase to each FS/NF-B's projected reimbursement rate for the applicable rate period or rate year by an equal percentage.

I. The payment reductions in the previous section(s) will be monitored in accordance with the monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services.

J. For the 2012/13 rate year, FS/NF-Bs will be reimbursed the facility specific Medi-Cal reimbursement rate effective on August 1, 2011, excluding the reductions specified in VI.G, plus the cost of complying with new state or federal mandates.

K. For the 2013/14 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3 percent of the maximum annual increase in the weighted average rate from the 2012/13 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

L. For the 2014/15 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3 percent of the maximum annual increase in the weighted average rate from the 2013/14 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

M. Beginning with the 2015/ l 6 rate year through July 31, 2017, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3.62 percent of the maximum annual increase in the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

N. Beginning with the 2017/18 rate year through July 31, 2020, the annual increase in the weighted average Medi-Cal reimbursement rate shall be 3.62 percent of the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

O. Beginning with the rate period of August 1, 2020, through December 31, 2020, the increase in the weighted average Medi-Cal reimbursement rate shall be 3.62 percent of the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

P. For the calendar year 2021 rate year, the increase in the weighted average Medi-Cal reimbursement rate shall be 3.5 percent of the weighted average rate from the previous rate period, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

VII. Peer-Grouping

The percentile caps for FS/NF-B facility labor, indirect care non-labor, administrative, and for the rate year beginning August 1, 2010 and subsequent rate years professional liability costs will be computed on a geographic peer-grouped basis. The median per diem direct resident care labor cost for each individual county will be subjected to a statistical clustering algorithm, based on commercially available statistical software. The statistical analysis of county costs will result in a defined and finite number of peer groups. A list of counties and their respective peer groups, along with a more detailed explanation of the peer-grouping methodology is available on-line at: https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTCAB1629.aspx, or by contacting the Department at:

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VIII. Determination of FS/NF-B Rates for State-Owned Facilities, Newly Certified Providers or Changes of Ownership

A. State-owned and operated FS/NF-Bs will receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate.

B. New FS/NF-Bs with no cost history in a newly constructed facility, in a location not previously licensed as a FS/NF-B, or an existing facility newly certified to participate in the Medi-Cal program will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.

C. FS/NF-Bs that have a change of ownership or changes of the licensed operator where the previous provider participated in the Medi-Cal program, the new owner or operator will continue to receive the reimbursement rate of the previous provider. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.

D. 1. FS/NF-Bs decertified for less than six months and upon recertification will continue to receive the reimbursement rate in effect prior to decertification. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.

2. FS/NF-Bs decertified for six months or longer and upon recertification will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.