

## **Table of Contents**

**State/Territory Name: California**

**State Plan Amendment (SPA)#: 13-040**

This file contains the following documents in the order listed:

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



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**APR 02 2014**

Toby Douglas, Director  
California Department of Health Care Services  
P.O. Box 997413, MS 0000  
Sacramento, CA 95899-7413

RE: California State Plan Amendment 13-040

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 13-040. This amendment, effective August 1, 2013, provides a new supplemental payment to freestanding skilled nursing facilities under the Quality and Accountability Supplemental Payment Program.

We conducted our review of your submittal according to the statutory requirements at sections 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 TN 13-040 is approved effective August 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.



If you have any questions, please call Mark Wong at 415-744-3561.

Sincerely,

A black rectangular redaction box covering the signature of Cindy Mann.

Cindy Mann  
Director

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>13-040</b>	2. STATE <b>CA</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		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 August 1, 2013	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447 Subpart B & 42 CFR 447 Subpart C		7. FEDERAL BUDGET IMPACT:	
		a. FFY 2013/44 \$21,114,358 \$3,389,393	
		b. FFY 2014/45 \$21,328,429 \$16,946,965	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
Supplement 4 to Attachment 4.19-D, page 20,21 & 22, 23, 24		None	
10. SUBJECT OF AMENDMENT: Quality and Accountability Supplemental Payment (QASP) Program, Freestanding Skilled Nursing Facilities Reimbursement Rates			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.	
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
 13. TYPED NAME: Toby Douglas 14. TITLE: Director 15. DATE SUBMITTED: SEP 25 2013		Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Avenue, Suite 71.326 P.O. Box 997417 Sacramento, CA 95899-7417	
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
		APR 02 2014	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
AUG 01 2013		 21. TYPED NAME: Penny Thompson 22. TITLE: Deputy Director, Policy & Financial Mgt. CMCs 23. REMARKS:	

**IX. Quality and Accountability Supplemental Payment**

- A. For the rate year beginning August 1, 2013, the Department will develop and implement the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) System. This program provides supplemental reimbursement for FS/NF-Bs, including FS/adult subacute facilities, that improve the quality of care rendered to its residents and would be in addition to the rate of payment FS/NF-Bs receive under the current reimbursement methodology.
- B. The Department, in consultation with CDPH and representatives from the long-term care industry, organized labor, and consumers; has developed a three tiered scoring methodology, with improvement scoring, for supplemental payments. The Minimum Data Set data file is obtained from the Centers for Medicare & Medicaid Services. The Department has a data use agreement with the Health Services Advisory Group for such purposes.
  1. 100 points are divided among the measurements with point values distributed for each quality indicator.

Measurement Area/Indicator	Possible Points:
<b>Minimum Data Set Clinical</b>	<b>100.00</b>
<b>Pressure Ulcers</b>	<b>33.34</b>
Pressure Ulcers: Long Stay	16.67
Pressure Ulcers: Short Stay	16.67
<b>Physical Restraints</b>	<b>33.34</b>
Physical Restraints: Long Stay	33.34
<b>Immunizations</b>	<b>33.32</b>
Influenza Vaccination: Long Stay	8.33
Influenza Vaccination: Short Stay	8.33
Pneumococcal Vaccination: Long Stay	8.33
Pneumococcal Vaccination: Short Stay	8.33

2. A facility's score for each indicator is as follows: a facility's performance based on MDS data is less than statewide average: zero points; at or above statewide average, up to but not including 75th percentile: half points; at or above the 75th percentile: full points. Additional indicators may be added in the future, subject to state and CMS approval.

In determining the statewide average and the 75th percentile for each indicator, the performance of all facilities, including ineligible facilities as defined in paragraph C below, are included.

3. Facilities receive an overall quality of care score when points from each of the quality measures are totaled.
4. Facilities that score at least 50.00 points are eligible for QASP payments.
5. The prior year (July 1 to June 30) performance is used for current state rate year payment as well as determination of the 75th percentile and statewide average. For example, MDS data from the performance period of July 1, 2012 to June 30, 2013 will be used to make state rate year 2013/14 payments.

The California Department of Public Health, in collaboration with the Department, computes each facility's score based on the MDS data. In using the MDS data file, the Long Stay Pressure Ulcer measure is adjusted so that unhealed pressure ulcers are not added back into the performance calculation.

6. Eligible facilities are grouped into three payment tiers based on their overall quality of care score. Facilities with scores from 0 to 49.99 points are grouped as Tier 1. Facilities with scores from 50.00 to 66.66 points are grouped into Tier 2. And facilities with scores from 66.67 to 100 points are grouped into Tier 3. Ineligible facilities, as defined in paragraph C, are grouped into Tier 0.

Tier 0 and Tier 1 facilities will not receive any supplemental payments under this QASP program component. The total pool amount for this component is converted into a Tier 2 per diem and a Tier 3 per diem. The Tier 3 per diem is set at 1-1/2 times the Tier 2 per diem. Each facility within Tier 2 and Tier 3 will receive a supplemental payment equal to the respective tier per diem times the facility's number of Medicaid bed days (including fee-for-service and managed care days) for the performance period.

The formula for determining the Tier 2 and Tier 3 per diems is as follows:

$$\text{Total pool} = (\text{Aggregate Tier 2 Medicaid bed days} \times \text{Tier 2 per diem}) + (\text{Aggregate Tier 3 Medicaid bed days} \times 1.5 \times \text{Tier 2 per diem})$$

$$\text{Tier 3 per diem} = \text{Tier 2 per diem} \times 1.5$$

\* Medicaid bed days total for the performance period includes fee-for-service and managed care days

The Department will utilize audited Medi-Cal fee-for-service and managed care bed days for determining payment amounts. The audited bed days are drawn from the audit reports used to establish 2013/14 Fee-For-Service per diem rates.

Note that any facility that does not have any Medicaid fee-for-service day either from the audit period or the payment period would not be included in the above computation and will not receive this payment.

Below is an example of a three tiered payment methodology:

**Total Payout \$36M**

<u>Payment Tier</u>	<u>Point Range</u>	<u># of SNFs</u>	<u>Payout per MCB</u>	<u>Total MCBs per Tier</u>	<u>Total Payout per Tier</u>	<u>Ave Payout per SNF</u>
<u>Tier 0<sup>1</sup></u>	-	<u>346</u>	<u>\$0.00</u>	<u>5,811,700</u>	<u>\$0</u>	<u>\$0</u>
<u>Tier 1</u>	<u>0 – 49.99</u>	<u>419</u>	<u>\$0.00</u>	<u>10,280,958</u>	<u>\$0</u>	<u>\$0</u>
<u>Tier 2</u>	<u>50.00 – 66.66</u>	<u>211</u>	<u>\$4.86</u>	<u>4,381,696</u>	<u>\$21,295,043</u>	<u>\$100,924</u>
<u>Tier 3</u>	<u>66.67- 100</u>	<u>119</u>	<u>\$7.29</u>	<u>2,019,628</u>	<u>\$14,723,088</u>	<u>\$123,723</u>
<u>Total Receiving Payment</u>	-	<u>330</u>				<u>\$109,146</u>
		<u>30.14%</u>				

- An additional component of the QASP program is the improvement scoring, where 10% of the payment allocation is set aside for facility improvements from the baseline year.

A facility's overall quality of care score as determined in paragraph B during a performance period is compared to the facility's score from the immediate prior performance period (base period). For example, for rate year 13/14 payment purposes, the facility's score for its performance in the 12/13 period is compared to its score for performance in the 11/12 base period. The difference is the improvement score. The improvement score for all facilities are ranked. Tier 0 facilities in the performance period are not included in the ranking as they are ineligible and not assigned a score. Additionally, a Tier 1/2/3 facility in the performance period would not be included in the Improvement ranking if the facility: 1) did not have any Medicaid bed days in the base period; 2) did not have any MDS clinical measure data in the base period; or 3) is a new facility in the performance period. Facilities in the top 20% in the improvement score ranking will receive a supplemental payment under the improvement component.

The total improvement pool amount specified in paragraph B.8 below is divided by the total number of Medicaid bed days (including both fee-for-

service and managed care days) for all facilities qualifying for an improvement component payment. The result is an improvement per diem. Each facility qualifying for an improvement component supplement payment will receive a supplement payment equal to the improvement per diem times its number of Medicaid days (including fee-for-service and managed care).

The Medicaid days are derived from the same source as Medicaid days in paragraph B.6.

Note that any facility that does not have any Medicaid fee-for-service day either in the performance period or the payment period would not be included in the above computation and will not receive this payment.

8. The aggregate supplemental payments will be funded by a pool of \$40,672,716 for the 2013/14 rate year. \$36,605,444 will be the total pool amount used to compute the Tier 2 and 3 per diems in paragraph B.6, and \$4,067,272 will be the total pool amount used to compute the improvement per diem in paragraph B.7. Annually, the pool amounts will be updated in the state plan and will be based on funds derived from general fund related to setting aside 1% of the weighted average Medi-Cal per diem rate, plus the savings from the Professional Liability Insurance being applied at the 75<sup>th</sup> percentile and the administrative penalties collected for facilities' failure to meet the nursing hours per patient day requirement, minus administration costs.

- C. For the rate year beginning on August 1, 2013, the Department will pay an annual lump sum Medicaid supplemental payment (as computed in paragraphs B.6 and B.7 above), by April 30, 2014, to eligible skilled nursing facilities, based on the following performance measures as specified in W&I Code Section 14126.022 (i):

1. Immunization rates
  2. Facility acquired pressure ulcer incidence
  3. The use of physical restraints.
- a. The Department will determine a facility ineligible to receive supplemental payments if the facility fails to meet the following minimum qualifying criteria:
    - i. A facility fails to provide supplemental data as requested by the Department.
    - ii. CDPH determines that a skilled nursing facility fails to meet the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

- iii. For the performance period, facility has Class AA/A citations. These citations are issued due to serious harm or death of a resident.
- iv. For the audit period, facility does not have any Medi-Cal bed days. Furthermore, facility must have Medi-Cal fee-for-service bed days in the payment period in order to receive a Medi-Cal fee-for-service supplemental payment.