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State/Territory Name: California

State Plan Amendment (SPA) #: 14-019

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

OCT 24 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 14-019

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 14-019. This amendment changes the interval for the cost report data periods for Intermediate Care Facilities for the Developmentally Disabled (including Habilitative and Nursing), under state plan authority effective August 1, 2014.

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 14-019 is approved effective August 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Mark Wong at (415) 744-3561 or Blake Holt at (415) 744-3754.

Sincerely,

[redacted]

Timothy Hill
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: **14-019**

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
August 1, 2014

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:

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2014-2015~~ 2013-2014 ~~$0~~ $219,070
b. FFY ~~2015-2016~~ 2014-2015 ~~$0~~ $1,314,422

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachments 4.19-D Pages 15.4c.1 and 15.4c.1a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachments 4.19-D Pages 15.4c.1

10. SUBJECT OF AMENDMENT:
To change the interval of the cost report data periods for Intermediate Care Facilities for the Developmentally Disabled (including habilitative and nursing), effective for the 2014-2015 rate year, and each rate year thereafter.

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.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: July 29th, 2014

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: OCT 24 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director FMP

23. REMARKS: Pen and ink changes made to Box 7 and Box 15 made by CMS as authorized by DHCS.

M.1. Notwithstanding paragraph F.9 of this Attachment (at page 15) and paragraphs K.6 through K.8, payments to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N), effective August 1, 2012, will be as specified in this paragraph M. The reimbursement rate will be one of the two rates listed below, as applicable:

a. If the facility's total projected costs, increased by 5 percent, are equal to or higher than the 2008-09 65th percentile, the applicable rate will be the 2008-09 65th percentile for the facility's peer group.

b. If the facility's total projected costs, increased by 5 percent, are lower than the 2008-09 65th percentile, the applicable rate will be the facility's total projected costs increased by 5 percent. However, no facility will receive a rate that is lower than the 2008-09 65th percentile for its respective peer group, reduced by 10 percent.

For purposes of subparagraphs M.1.a and M.1.b, DHCS will determine each facility's projected costs by updating the facility's costs taken from cost reports that would have otherwise been used for rate-setting purposes in paragraph F (at page 13) for a given rate year (i.e., facility costs taken from the cost reports ending during State fiscal year July 1, 2010, through June 30, 2011 will be used as a basis for projected costs for the period from August 1, 2012, through July 31, 2013).

Notwithstanding subparagraphs M.1.a and M.1.b, effective August 1, 2014, DHCS will increase the interval between the cost reporting periods and the rate year in order to determine each facility's projected costs by utilizing the reported or audited costs that were used to calculate the 2013-14 rates.

Beginning with the 2015-16 rate year, and each rate year thereafter, DHCS will utilize reported or audited costs with fiscal periods ending in the calendar year that is two years prior to the beginning of the rate year (August 1) to establish each facility's projected rates (i.e., facility's cost report endings on or within January 1, 2013, through December 31, 2013 will be used to calculate the rates for the period from August 1, 2015, through July 31, 2016).

2. Each ICF/DD, ICF/DD-H, and ICF/DD-N will retain its supporting financial and statistical records for a period of not less than three years following the date of submission of its cost report and will make such records available upon request to authorized state or federal representatives, as described in Welfare and Institutions Code, Section 14124.1.

3. The reimbursement rate methodology for ICF/DD, ICF/DD-H, and ICF/DD-Ns may include more or less than twelve months and/or more than one cost report, as long as the fiscal periods all end within the timeframe specified for rate-setting.

4. DHCS will exclude any cost report or supplemental schedule or portion thereof that it deems inaccurate, incomplete, or unrepresentative. If any cost report or supplemental schedule is excluded, the rate set forth in paragraph M.10 will apply.

5. ICF/DD, ICF/DD-H, and ICF/DD-Ns that no longer participate in the Medi-Cal Program will be excluded from the rate-setting process.