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State/Territory Name: California

State Plan Amendment (SPA) #: 14-032

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

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

Financial Management Group

MAR 26 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 14-032

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 14-032. This amendment updates the pool amounts and makes some changes to the quality measures involved in the Quality and Accountability Supplemental Payment (QASP) program for freestanding skilled nursing facilities, effective August 1, 2014.

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 14-032 is approved effective August 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

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

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: **14-032**

2. STATE: CA

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:
42 CFR 447 Subpart B & 42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2014/15~~ 2013/14 ~~$45,033,943~~ $7,500,000
b. FFY ~~2015/16~~ 2014/15 ~~$45,048,943~~ $37,500,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 4 to Attachment 4.19-D, ~~page 20,21 & 22~~ page 20-24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 4 to Attachment 4.19-D, page 20-24

10. SUBJECT OF AMENDMENT:
Quality and Accountability Supplemental Payment (QASP) Program, Freestanding Skilled Nursing Facliities Reimbursement Rates

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:

13. TYPED NAME:

14. TITLE:

15. DATE SUBMITTED:

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: MAR 26 2015

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, FMG

23. REMARKS:
Pen and ink changes to Box 7,8, and 9 with state's concurrence.

FORM HCFA-179 (07-92)

IX. Quality and Accountability Supplemental Payment

A. For the rate year beginning August 1, 2014, 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:
Minimum Data Set Clinical	**100.00**
Influenza Vaccination: Short Stay	8.33
Pneumococcal Vaccination: Short Stay	8.33
Facility Acquired Pressure Ulcer Incidence	16.66
The Use of Physical Restraints	16.67
Urinary Tract Infection	16.67
Control of Bowel or Bladder	16.67
Self-Reported Moderate to Severe Pain	16.67

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. Indicators may be added or removed 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, 2013 to June 30, 2014 will be used to make state rate year 2014/15 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:

   Total pool = (Aggregate Tier 2 Medicaid bed days* x Tier 2 per diem) + (Aggregate Tier 3 Medicaid bed days* x 1.5 x Tier 2 per diem)

   Tier 3 per diem = Tier 2 per diem x 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 2014/15 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 $90M

Payment Tier	Point Range	# of SNFs	Payout per MCBD	Total MCBDs per Tier	Total Payout per Tier	Ave Payout per SNF
Tier 0		346	$0.00	5,811,700	$0	$0
Tier 1	0 – 49.99	419	$0.00	10,280,958	$0	$0
Tier 2	50.00 – 66.66	211	$12.15	4,381,696	$53,237,607	$252,310
Tier 3	66.67-100	119	$18.23	2,019,628	$36,807,720	$309,307
Total Receiving Payment		**330** **30.14%**				**$272,865**

7. 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 14/15 payment purposes, the facility's score for its performance in the 13/14 period is compared to its score for performance in the 12/13 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 $90,000,000 for the 2014/15 rate year. $81,000,000 will be the total pool amount used to compute the Tier 2 and 3 per diems in paragraph B.6, and $9,000,000 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 75th 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, 2014, the Department will pay an annual lump sum Medicaid supplemental payment (as computed in paragraphs B.6 and B.7 above), by April 30, 2015, to eligible skilled nursing facilities, based on the following performance measures as specified in W&I Code Section 14126.022 (i):

1. Immunization rates (short stay only)
2. Facility acquired pressure ulcer incidence
3. The use of physical restraints.
4. Urinary Tract Infection
5. Control of Bowel or Bladder
6. Self-Reported Moderate to Severe Pain
7. Compliance with the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

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.