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State/Territory Name: California

State Plan Amendment (SPA) #: 15-032A

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

APR 11 2016

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 15-032-A

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 15-032-A. This State plan amendment (SPA) updates Attachment 4.19-D to extend the facility-specific rate setting methodology for freestanding skilled nursing facilities, including subacute care units of freestanding skilled nursing facilities, through July 31, 2020 and limits the maximum annual increase in the weighted average Medi-Cal reimbursement rate for these facilities in the 2015/16 rate year to 3.62 from the previous year (plus the projected cost of complying with state and federal regulations).

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 15-032-A is approved effective August 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: 15-032 A

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, 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:
CCR title 22, section 51124.5

7. FEDERAL BUDGET IMPACT:
a. FFY 2014/15 $ 12,787,929.00
a. FFY 2015/16 $ 77,190,499.00
~~b. FFY 2016/17 $ 79,984,795.00~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D, Page 1

Supplement 4 to Attachment 4.19D, pages 1, 17

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplement 4 to Attachment 4.19-D pages; 1,17, ~~23 & 24~~
Attachment 4.19D, Page 1

10. SUBJECT OF AMENDMENT:
Extends the AB 1629 facility specific rate methodology, and Quality Assurance Fee, ~~and Quality and Accountability Supplemental Payment Program~~ from July 31, 2015 to July 31, 2020.

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:
Mari Cantwell

14. TITLE:
Director

15. DATE SUBMITTED:
SEP 30 2015

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:
APR 11 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
AUG 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Kristin Fan

22. TITLE:
Director, FMC

23. REMARKS:

Pen and ink changes made to Boxes 1, 7,8, 9, and 10 with state's 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. Therefore, the rate methodology in effect as of July 31, 2005, continues to be described in Attachment 4.19-D, Pages 1 through 22 of this State Plan.

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.

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: (1) 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, 2011. 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. ABX1 19, 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.

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

F. 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 year

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 31, 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 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 2015/16 rate year through July 31, 2020 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.