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**State/Territory Name: California**

**State Plan Amendment (SPA) #: 18-034**

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 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**

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

SEP 06 2018

RE: California State Plan Amendment 18-0034

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 18-0034. This State Plan Amendment (SPA), effective August 1, 2018, renews the Quality Supplemental Payment (QASP) Program for rate year 2018-19.

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 18-0034 is approved effective August 1, 2018. 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: 18-0034

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, 2018

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 2018 $7,333,333
a. FFY 2019 $36,666,667

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 4 to Attachment 4.19-D pages 20, ~~20a~~, 21, 23, 24

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplement 4 to Attachment 4.19-D pages 20, ~~20a~~, 21, 23, 24

10. SUBJECT OF AMENDMENT:
Extends the Quality and Accountability Supplemental Payment program from August 1, 2018 to July 31, 2019, and changes the available funds pools.

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:
State Medicaid Director

15. DATE SUBMITTED:
August 7, 2018

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: SEP 06 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS: Redline changes made to Boxes 8 and 9 with state concurrence.

**IX. Quality and Accountability Supplemental Payment**

A. For the rate years beginning August 1, 2017 and August 1, 2018, 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 California Department of Public Health (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 (CMS). 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 |
| Facility Acquired Pressure Ulcer: Long Stay | 11.111 |
| Physical Restraints: Long Stay | 11.111 |
| Influenza Vaccination: Short Stay | 5.55575 |
| Pneumococcal Vaccination: Short Stay | 5.55575 |
| Urinary Tract Infection: Long Stay | 11.111 |
| Control of Bowel/Bladder: Long Stay | 11.111 |
| Self-Report Pain: Short Stay | 5.55575 |
| Self-Report Pain: Long Stay | 5.55575 |
| Activities of Daily Living: Long Stay | 11.111 |
| Direct Care Staff Retention | 11.111 |
| 30 Day All-Cause Readmission | 11.111 |

2. A facility's score for each indicator is as follows: a facility's performance 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.

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

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

Tier 3 per diem = Tier 2 per diem x 1.5

* Medi-Cal bed days total for the audit 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 2017/18 and 2018/19 Fee-For-Service per diem rates. Note that any facility that does not have any Medi-Cal Fee-For-Service days from audit period would not be included in the above computation and will not receive this payment.

will receive a supplement payment equal to the improvement per diem times its number of Medi-Cal days (including Fee-For-Service and managed care).

The Medi-Cal days are derived from the same source as Medi-Cal days in paragraph B.6. Note that any facility that does not have any Medi-Cal Fee-For-Service days in the audit period would not be included in the above computation and will not receive this payment.

8. The aggregate supplemental payment amount for the 2017/18-rate year will be funded by a pool of $88,000,000, of which $2,000,000-will be used to fund the delayed payment pool. The aggregate supplemental payment amount for the 2018/19 rate year will be funded by a pool of $88,000,000, of which $4,000,000 will be used to fund the delayed payment pool. Ninety (90) percent of the remaining amount will be used to compute the Tier 2 and 3 per diems in paragraph B.6, and the remaining ten (10) percent will be 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 the 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.

9. The 2017/18 delayed payment pool will be used to fund delayed QASP payments which are made after the primary payment, but before June 30, 2019. The 2018/19 delayed payment pool will be used to fund delayed QASP payments which are made after the primary payment, but before June 30, 2020. An example of a delayed payment would be where a facility was originally determined to be ineligible in accordance with paragraph C.a, at the time of primary payment, but such determination was later successfully appealed by the facility within the above timeline. Delayed supplemental or improvement payments will be made on a per diem basis at the respective per diem rate established by the respective rate year calculation. No rate year's per diem calculations will be altered by delayed payments, and no payments originally made to other facilities will be affected by delayed payments. A facility eligible for a delayed payment will receive the established Tier 2 or Tier 3 per diem, based on its own quality of care score. A facility eligible for a delayed payment will receive the established improvement per diem, if its improvement score ranks in the top 20th percentile when included in the ranking of all eligible facilities. Any remaing funds from the delayed payment pool will be applied to the following rate year's aggregate supplemental payments amount. If the amount in the delayed pool is insufficient to pay all computed delayed payments for the current Fiscal Year, additional funds will be made available by deducting from next Fiscal Year's total payment pool so that all facilities eligible for a delayed payment will be paid their computed payments in full.

C. For each applicable rate year beginning August 1, 2017, the Department will pay an annual lump sum Medi-Cal supplemental payment (as computed in paragraphs B.6 and B.7 above), by April 30th of the applicable rate year, (and delayed payments by June 30th of the year following the end of the applicable rate year as provided in paragraph 9 on page 23), to eligible skilled nursing facilities, based on the following performance measures as specified in W&I Code Section 14126.022 (i), as in effect on June 2016:

1. Facility Acquired Pressure Ulcer: Long Stay
2. Physical Restraints: Long Stay
3. Influenza Vaccination: Short Stay
4. Pneumococcal Vaccination: Short Stay
5. Urinary Tract Infection: Long Stay
6. Control of Bowel/Bladder: Long Stay
7. Self-Reported Pain: Short Stay
8. Self-Reported Pain: Long Stay
9. Activities of Daily Living: Long Stay
10. Direct Care Staff Retention
11. 30 Day All-Cause Readmission

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 timely 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.