

**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. [AB X1 19, extends the operative date to July 31, 2013.](#)
- 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 years.

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- G. The percentiles in labor costs, indirect care non-labor costs, and administrative costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis.

## VI. Limitations on the Medi-Cal Facility-Specific Reimbursement Rate Calculation

In addition to limitations described in Section V.C.4.e. of this Supplement (FRVS reimbursement limitations), the aggregate facility-specific Medi-Cal payments calculated in accordance with the methodology set forth in Section V of this Supplement will be limited by the following:

- A. For the 2005/06 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed eight percent of the weighted average reimbursement rate for the 2004/05 rate year, as adjusted for the change in the cost to the FS/NF-B to comply with the skilled nursing facility quality assurance fee for the 2005/06 rate year, plus the total projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- B. For the 2006/07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed five percent of the weighted average Medi-Cal rate for the 2005/06 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- C. For the 2007/08 and 2008/09 rate years, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medi-Cal rate for the 2006/07 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- D. For the 2009/10 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not be increased over the weighted average Medi-Cal rate for the 2008-09 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- E. For the 2010/11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3.93 percent of the maximum annual increase in the weighted average rate from the 2009/10 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.
- F. For the 2011/12 rate year, the maximum annual increase ~~in the weighted average~~ Medi-Cal reimbursement rate will not exceed 2.4 percent ~~off from~~ the ~~maximum annual increase in the weighted average rate from the 2010/11 rate year~~ effective May 31, 2011, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

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G. 1.For services provided on and after June 1, 2011 through July 31, 2012, Medi-Cal payments will equally be reduced by 10 percent.

2.For managed care plans that contract with the Department to provide skilled nursing services, the Department will reduce payments by the actuarial equivalent of reimbursements calculated in G.(1) for contracts amendments or change orders effective on, or after, July 1, 2011.

H For the 2012/13 rate year, provisions of the current legislation require that the weighted average Medi-Cal reimbursement rate increase will be adjusted by the Department as follows:

1. Facility specific reimbursement rates will not be less than the Medi-Cal rate paid to FS/NF-B's on May 31, 2011.
2. The Department may increase the Medi-Cal reimbursement rates by an amount equal to the difference between the actual percentage increase in the 2011/12 rate year and the maximum 2.4 percent increase.
3. The Department will set aside 1 percent of the weighted average Medi-Cal reimbursement rate and transfer the General Fund portion into the Quality and Accountability Supplemental Payment Fund.
4. The Department will determine the amount of reduced payments for each FS/NF-B, equivalent to the 10 percent rate 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.
5. For managed care plans that contract with the Department to provide skilled nursing services, the Department will adjust payments by the actuarial equivalent of reimbursements calculated in G.(2) for contracts amendments or change orders effective on, or after, July 1, 2011.
6. If the Department fails to provide the supplemental payment required under numbers (4) and (5), beginning on January 1, 2013, the Skilled Nursing Facility Quality Assurance Fee will not be enforceable against any FS/NF-B. Any amount collected by the Department during the 2012-13 rate year pursuant to Article 7.6 (commencing with Section 1324.20 of Chapter 2 of Division 2 of the Health and Safety Code, will be refunded to each facility not later than February 1, 2013.

HI. 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, and VI. D, VI. E, VI.G and VI.H 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.

## VII. Peer-Grouping

The percentile caps for FS/NF-B facility labor, indirect care non-labor, administrative costs, and

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professional liability costs will be computed on a geographic peer-grouped basis. The median per diem direct resident care labor cost for each individual county will be subjected to a statistical clustering algorithm, based on commercially available statistical software. The statistical analysis of county costs will result in a defined and finite number of peer groups. A list of counties and their respective peer groups, along with a more detailed explanation of the peer-grouping methodology is available on-line at: <http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629Policy.aspx>, or by contacting the Department at:

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### **VIII. Determination of FS/NF-B Rates for State-Owned Facilities, Newly Certified Providers or Changes of Ownership**

- A. State-owned and operated skilled nursing facilities will receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate.
- B. New FS/NF-Bs with no cost history in a newly constructed facility, in a location not previously licensed as a FS/NF-B, or an existing facility newly certified to participate in the Medi-Cal program will receive an interim reimbursement rate based on the peer-grouped weighted average Medi-Cal reimbursement rate. The Department will calculate the facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective on August 1 of each rate year. The difference between the FS/NF-B's interim per diem payment rate and the facility-specific per diem payment rate calculated based on Section V of this Supplement will be determined upon audit or review of the cost report and/or supplemental report. The Department will adjust the difference in reimbursement rate on a prospective basis, consistent with the methodology described in Section IV.C.2 of this Supplement.
- C. Changes of ownership or changes of the licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. In instances where the previous provider participated in the Medi-Cal program, the Department will reimburse the new owner or operator the per diem payment rate of the previous provider until the new owner or operator has submitted six or more months of Medi-Cal cost and/or supplemental data and the Department has audited these costs. The Department will calculate the rate prospectively and it will be effective on August 1 of each rate year. If, upon audit or review, the per diem payment rate calculated for the new owner or operator is less than the per diem payment rate of the previous owner or operator, the Department will prospectively adjust the new owner's or operator's per diem payment rate as calculated in this Supplement.

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- D. 1. Facilities decertified for six months or less will continue to receive the rate in effect prior to decertification. The Department will calculate the facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective on August 1 of each rate year.
2. Facilities decertified for six months or longer will receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate. The Department will calculate the facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective on August 1 of each rate year.

### IX. Quality and Accountability Supplemental Payment

- A. For the rate year beginning August 1, 2010, the Department will develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System. This program will be phased in and provides supplemental reimbursement for FS/NF-Bs that improve the quality and accountability 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. For the rate year beginning August 1, 2010, the State treasury will create the Skilled Nursing Facility Quality and Accountability Special Fund. The fund will be continuously appropriated without regard to fiscal year to the state for making quality and accountability payments to facilities that meet or exceed performance measures. The fund will contain monies deposited through:
1. Administrative penalties for failure to meet the nursing hours per patient requirement imposed beginning with rate year starting on August 1, 2010.
  2. Savings achieved from setting the professional liability insurance cost category, as described in V.C.4 of this supplement; including any insurance deductible costs paid by the facility at the 75<sup>th</sup> percentile, instead of a direct pass through cost at 100 percent.
  3. For the 201~~12~~/1~~23~~ rate year, the Department will set aside 1 percent of the weighted average Medi-Cal reimbursement rate and transfer the General Fund portion in to the Quality and Accountability Supplemental Payment Fund.
- C. For the fiscal year beginning August 1, 2010, the Department , in consultation with representatives from the long-term care industry, organized labor, and consumers, will establish and publish quality and accountability measures.

D. For the rate year beginning on August 1, 2012, the department will pay a supplemental payment, by April 30, 2013, to skilled nursing facilities based on all of the performance measures defined in W&I Code Section 14126.022 (i).

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1. The department may determine a facility ineligible to receive supplemental payments if a facility fails to provide supplemental data as requested by the department.
  
2. For managed care plans that contract with the Department to provide skilled nursing services, the Department will adjust payments by the actuarial equivalent of reimbursements calculated in IX.D for contracts amendments or change orders effective on, or after, July 1, 2012.

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