



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

JUL 29 2014

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Dear Ms. Lee:

STATE PLAN AMENDMENT 14-019

The Department of Health Care Services (DHCS) is submitting the enclosed State Plan Amendment (SPA) 14-019 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.

Enclosed are SPA pages 15.4c.1 and 15.4c.1a of Attachment 4.19-D, which adds additional language to Subsection M.1 to describe specific changes to the cost period data periods.

If you have questions or concerns regarding the proposed provisions, please contact Ms. Connie Florez, Chief of the Fee For Service Rates Development Division, at (916) 552-9589.

Enclosures

cc: See Next Page

Ms. Hye Sun Lee
Page 2

cc: Connie Florez, Chief
Fee For Service Rates Development Division
1501 Capitol Avenue, Suite 71.4118
MS 4600
Sacramento, CA 95814

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
14-019

2. STATE
California

FOR: HEALTH CARE FINANCING ADMINISTRATION

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** \$0
b. FFY **2015-2016** \$0

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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.

ORIGINAL SIGNED

16. RETURN TO:

Toby Douglas

14. TITLE:

Director

15. DATE SUBMITTED:

**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:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

- 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.

TN 14-019
Supersedes
TN N/A

Approval Date _____

Effective Date August 1, 2014

SPA Impact Form

State/Title/Plan Number: 14-019

Federal Fiscal Impact: None

Number of People Affected by Enhanced Coverage, Benefits or Retained Eligibility: N/A

Number of Potential Newly Eligible People: N/A
or

Eligibility Simplification: No

Number of People Losing Medicaid Eligibility: N/A

Reduces Benefits: No

Provider Payment Increase: No

Delivery System Innovation: No

Comments/Remarks: State Plan Amendment (SPA) 14-019 is proposing to change the interval of the cost report data periods for Intermediate Care Facilities for the Developmentally Disabled (including Habilitative and Nursing).

DHS Contact:

Julie Hoang
Long Term Care Reimbursement Unit
Long Term Care Section
Fee-For-Service Rates Development Division
Department of Health Care Services
(916) 445-2701
Julie.Hoang@dhcs.ca.gov

Date: July 8, 2014

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER Z-2014-0708-06	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
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For use by Office of Administrative Law (OAL) only

<p>RECEIVED FOR FILING PUBLICATION DATE</p> <p>JUL 08 '14 JUL 18 '14</p> <p>Office of Administrative Law</p> <p>NOTICE</p>	<p>REGULATIONS</p>
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AGENCY WITH RULEMAKING AUTHORITY Department of Health Care Services	AGENCY FILE NUMBER (if any)
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A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE Changing interval of the cost report data periods		TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE July 18, 2014
3. NOTICE TYPE <input type="checkbox"/> Notice re Proposed Regulatory Action <input checked="" type="checkbox"/> Other	4. AGENCY CONTACT PERSON Sandy Yien		TELEPHONE NUMBER (916) 552-9636	FAX NUMBER (Optional)
OAL USE ONLY	<input type="checkbox"/> ACTION ON PROPOSED NOTICE <input type="checkbox"/> Approved/Submitted <input type="checkbox"/> Approved/Modified <input type="checkbox"/> Disapproved/Withdrawn	NOTICE REGISTER NUMBER	PUBLICATION DATE	

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
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2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)	
SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT
	AMEND
TITLE(S)	REPEAL

3. TYPE OF FILING

<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346)	<input type="checkbox"/> Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.	<input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h))	<input type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
<input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)	<input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input type="checkbox"/> File & Print	<input type="checkbox"/> Print Only
<input type="checkbox"/> Emergency (Gov. Code, §11346.1(b))		<input type="checkbox"/> Other (Specify) _____	

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	<input type="checkbox"/> Effective on filing with Secretary of State	<input type="checkbox"/> §100 Changes Without Regulatory Effect	<input type="checkbox"/> Effective other (Specify) _____
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6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660)	<input type="checkbox"/> Fair Political Practices Commission	<input type="checkbox"/> State Fire Marshal
<input type="checkbox"/> Other (Specify) _____		

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
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8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

DATE
7-8-14

Connie Florez, Chief of Fee For Service Rates Development Division

For use by Office of Administrative Law (OAL) only



Department of Health Care Services
MEMORANDUM

DATE: JUL 08 2014

TO: Debra Cornez, Director
Office of Administrative Law
300 Capitol Mall,

FROM: Connie Florez, Chief
Fee For Service Rates Development Division
1501 Capitol Avenue, Suite 71.4118
MS 4600

SUBJECT: Request to Publish "Notice of General Public Interest" in the California
Regulatory Notice Register

This memorandum transmits for publication the attached "Notice of General Public Interest." The California Department of Health Care Services intends to submit an amendment to the State Plan regarding to change the interval of the cost report data periods for Intermediate Care Facilities for the Developmentally Disabled (including Habilitative and Nursing).

If you have any questions, please contact Ms. Sandy Yien, Chief of the Long Term Care Reimbursement Unit, at (916) 552-9636.

cc: Sandy Yien, Chief
Long Term Care Reimbursement Unit
1501 Capitol Avenue, Suite 71.4239
MS 4600

NOTICE OF GENERAL PUBLIC INTEREST

DEPARTMENT OF HEALTH CARE SERVICES TO CHANGE THE INTERVAL OF THE COST REPORT DATA PERIODS FOR INTERMEDIATE CARE FACILITIES FOR THE DEVELOPMENTALLY DISABLED (INCLUDING HABILITATIVE AND NURSING)

The Department of Health Care Services (DHCS) is revising 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.

For the 2014-2015 rate year, beginning August 1, 2014, DHCS will determine each facility's projected costs by utilizing the reported or audited costs that were used to calculate the rates for the 2013-2014 rate year, previously implemented on May 27, 2014.

Beginning with the 2015-2016 rate year, and each rate year thereafter, in order to determine each facility's projected costs, 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).

PUBLIC REVIEW AND COMMENTS

Written comments and/or requests for review may be submitted to:

Ms. Connie Florez, Chief
Department of Health Care Services
1501 Capitol Avenue, Suite 71.4118
MS 4600
P.O. Box 997417
Sacramento, CA 95899-7417