



JENNIFER KENT
Director

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



EDMUND G. BROWN JR.
Governor

SEP 29 2016

Ms. Henrietta Sam-Louie
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

STATE PLAN AMENDMENT 16-037: QUALITY AND ACCOUNTABILITY
SUPPLEMENTAL PAYMENT PROGRAM

Dear Ms. Sam-Louie:

The Department of Health Care Services (DHCS) is submitting the enclosed State Plan Amendment (SPA) 16-037 for your review and approval.

On June 24, 2015, AB 119 (Statutes 2015, Chapter 17) was enacted into law, effective August 1, 2015. AB 119 authorizes the renewal of the Quality and Accountability Supplemental Payment Program (QASP) for five years, and directs DHCS to implement or create certain quality measures for the QASP. This SPA addresses the renewal of the QASP and the implementation of two quality measures.

SPA 16-037 revises or adds language to the provisions set forth in the following sections of the State Plan:

- Supplement 4 to Attachment 4.19 D – pages 20 - 24

DHCS is submitting the following SPA documents for your review and approval:

- HCFA 179- Transmittal and Notice of Approval of State Plan Material
- Pages 20 - 24 of Supplement 4 to Attachment 4.19 D (clean version)
- Pages 20 - 24 of Supplement 4 to Attachment 4.19 D (redlined version)

Ms. Henrietta Sam-Louie
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If you have any questions regarding this SPA, please contact Ms. Connie Florez, Chief,
Fee-For-Service Rates Development Division, at (916) 552-9600

Sincerely,

ORIGINAL SIGNED

State Medicaid Director
Department of Health Care Services

Enclosures

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

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

1. TRANSMITTAL NUMBER:
16-037

2. STATE
CA

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, 2016

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 2015/16 \$ 7,500,000
a. FFY 2016/17 \$ 45,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 4 to Attachment 4.19-D pages 20, 20b, 21, 22, 23, 24

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Supplement 4 to Attachment 4.19-D pages 20, 20b, 21, 22, 23, 24

10. SUBJECT OF AMENDMENT:

Extends the Quality and Accountability Supplemental Payment program from through July 31, 2020, adds activities of daily living and direct care staff retention quality measures.

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

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED: SEP 29 2016

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:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

IX. Quality and Accountability Supplemental Payment

- A. For the rate year beginning August 1, 2015, and each rate year until July 31, 2020, 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	
Minimum Data Set Clinical	100.00
Influenza Vaccination: Short Stay	6.25
Pneumococcal Vaccination: Short Stay	6.25
Facility Acquired Pressure Ulcer Incidence	12.50
Urinary Tract Infection	12.50
The Use of Physical Restraints	12.50
Control of Bowel or Bladder	12.50
Self-Reported Pain: Short Stay	6.25
Self-Reported Pain: Long Stay	6.25
Activities of Daily Living: Long Stay	12.50
Direct Care Staff Retention	12.50

- 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 fiscal year (July 1 to June 30) performance is used for subsequent 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 rate year 2014/15 payments.

CDPH, in collaboration with the Department, computes each facility's score based on the MDS data for the clinical quality measures and facility cost reports for the staff retention measure. 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 Tier 2 or Tier 3 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 1.5 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 Medi-Cal 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:

$$\text{Total pool} = (\text{Aggregate Tier 2 Medi-Cal bed days}^* \times \text{Tier 2 per diem}) + (\text{Aggregate Tier 3 Medi-Cal bed days}^* \times 1.5 \times \text{Tier 2 per diem})$$

$$\text{Tier 3 per diem} = \text{Tier 2 per diem} \times 1.5$$

* Medi-Cal bed days total for the performance period includes fee-for-service and managed care days

The Department will utilize managed care and 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 Fee-For-Service per diem rates for the respective rate year. Note that any facility that does not have any Medi-Cal fee-for-service day either from the performance 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 MCBBD	Total MCBDDs 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				\$272,865
		30.14%				

- 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 Medi-Cal 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 20th percentile 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 Medi-Cal 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 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 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 each 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.
- C. For the rate year beginning on August 1, 2015, and each rate year until July 31, 2020, the Department will pay an annual lump sum Medi-Cal supplemental payment (as computed in paragraphs B.6 and B.7 above), by April 30, 2016, 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 2015:
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.
 8. Activities of Daily Living
 9. Direct Care Staff Retention
- 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 performance 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.

Summary of Federal Budget Impact for Quality and Accountability Supplemental Payment Program

<u>FFY</u>	<u>Explanation</u>	<u>Total Funds</u>	<u>Federal Fund Portion</u>	<u>Federal Budget Impact</u>
2015-16	2 months of SFY 2016-17	\$ 90,000,000	\$ 45,000,000	\$ 7,500,000.00
2016-17	10 months of SFY 2016-17 + 2 months SFY 2017-18	\$ 90,000,000	\$ 45,000,000	\$ 45,000,000.00
2017-18	10 months of SFY 2017-18 + 2 months SFY 2018-19	\$ 90,000,000	\$ 45,000,000	\$ 45,000,000.00