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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 will be 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. This legislation will become inoperative on July 31, 2008. Provisions of AB 1629 mandate that the new facility-specific rates during rate years 2005/06 and 2006/07, shall not be less than the rate methodology in effect as of July 31, 2005. 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, pediatric subacute and transitional care.

C. The routine service per diem includes all equipment, supplies and services necessary to provide appropriate nursing care to long-term care patients or intermediate care for the developmentally disabled, except those items listed as separately payable or personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility as part of patient care and periodic hair cuts), and television rental.

D. Not included in the payment rate and to be billed separately by the provider thereof,

subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are:

1. Allied health services ordered by the 'attending physician, excluding respiratory therapy.
2. Alternating pressure mattresses/pads with motor.
3. Atmospheric oxygen concentrators and enrichers and accessories.
4. Blood, plasma and substitutes.
5. Dental services.
6. Durable medical equipment as specified in Section 51321(g).
7. Insulin.
8. Intermittent positive pressure breathing equipment.
9. Intravenous trays, tubing and blood infusion sets.
10. Laboratory services.
11. Legend drugs.
12. Liquid oxygen system.
13. MacLaren or Pogon Buggy.
14. **Medical supplies.**
15. Nasal cannula.
16. Osteogenesis stimulator device.
17. Oxygen (except emergency).
18. Parts and labor for repairs of durable medical equipment if originally separately payable or owned by beneficiary.
19. Physician services.
20. Portable aspirator.
21. Portable gas oxygen system and accessories.
22. Precontoured structures (VASCO-PASS, cut out foam).
23. Prescribed prosthetic and orthotic devices for exclusive use of patient.
24. Reagent testing sets.
25. Therapeutic aid fluid support system/Beds.
26. Traction equipment and accessories.
27. Variable height beds.
28. X-rays.

For subacute, pediatric subacute, and transitional levels of care, items can be separately billed as specified in Title 22 CCR, Sections 51511.5(d), 51511.6(f) and 51511.3(f) respectively (see Appendix 4).

E. The application of the methodology described in this Attachment, with the most recent update factors and constants used to project costs, is included in an annual rate study conducted by the Department prior to August 1st each year and required by the CCR as an evidentiary base for the filing of new and/or revised regulations. This annual rate study is designated as Supplement 1, and will be provided to the Centers for Medicare and Medicaid Services (CMS) by December 31st of the rate year. The rates will become effective as provided for by the State's Budget Act, typically on August 1 of each year.

F. If a freestanding facility's change in bedsize has an impact on the reimbursement rate, the lesser of the existing rate or the new rate shall prevail until the next general rate change. This is to deter a facility from changing bedsize groupings for the purpose of maximizing reimbursement.

G. Notwithstanding any other provisions of this State Plan, the reimbursement rate shall be limited to the usual charges made to the general public, not to exceed the maximum reimbursement rates set forth by this Plan.

H. Within the provisions of this Plan, the following abbreviations shall apply: NF-nursing facility; ICF/DD-intermediate care facility for the developmentally disabled; ICF/DD-H-intermediate care facility for the developmentally disabled habilitative; ICF/DD-N-intermediate care facility for the developmentally disabled nursing; STP-special treatment program; and DP-distinct part.

I. All long term care providers shall be required to be certified as qualified to participate in the Medi-Cal program and must also meet the requirements of Section 1919 of the Social Security Act. In order to assure that reimbursement takes into account the cost of compliance with statutory requirements, NFs shall be reimbursed based on the following criteria: (Refer to Table 1 for a specific list)

1. Resident acuity:

NFs shall be reimbursed based on the provision of the following services: level A; level B; subacute -- ventilator and non-ventilator dependent; pediatric subacute -- ventilator and non-ventilator dependent; and transitional inpatient care -- rehabilitative and medical. Level A services are provided to a NF resident who requires medically necessary services of relatively low intensity. Level B, subacute, pediatric subacute, and

transitional inpatient care services are provided to a NF resident who requires medically necessary services of varying degrees of higher intensity. The criteria for the acuity of NF services and staffing standards are contained in state regulations and policy manuals.

2. Organization type:

(a) Freestanding facilities.
(b) DP/NFs - A distinct part nursing facility is defined as any nursing facility (level A or B) which is licensed together with an acute care hospital.
(c) Swing-beds in rural acute care facilities.
(d) Subacute units of freestanding or distinct part NFs - A subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).
(e) Pediatric subacute units of freestanding or distinct part NFs - A pediatric subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).
(f) Transitional inpatient care units of freestanding or distinct part NFs -- A transitional inpatient care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).

3. Bedsize:

As listed below, in determining the appropriate bedsize categories for reimbursement purposes, a facility's total number of beds shall be used, irrespective of patient acuity level or licensure. A single facility licensed as a distinct part to provide two or more patient acuity levels, or a single facility that has separate licenses for different patient acuity levels, shall have the bedsize for each patient acuity level determined by total beds within the actual physical plant. The bedsize used to establish rates shall be based upon the data contained in the cost report(s) included in the rate study.

(a) NF level B...1-59, and 60+
(b) DP/NF level B...no bedsize category
(c) NF level B/subacute...no bedsize category
(d) DP/NF level B/subacute...no bedsize category
(e) NF level B/pediatric subacute...no bedsize category

(f) DP/NF level B/pediatric subacute...no bedsize category
(g) NF level A... no bedsize category
(h) DP/NF level A ... no bedsize category
(i) ICF/DD...1-59, 60+ and 60+ with a distinct part
(j) ICF/DD-H...4-6 and 7-15
(k) ICF/DD-N...4-6 and 7-15
(l) Swing-beds...no bedsize category
(m) Transitional inpatient care...no bedsize category

4. Geographical location:

(a) Freestanding NF levels A and B and DP/NF level A:
(1) Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, and Sonoma counties.
(2) Los Angeles county.
(3) All other counties.
(b) DP/NF level B, freestanding NF level B/subacute and pediatric subacute, DP/NF level B/subacute and pediatric subacute, transitional inpatient care, ICF/DDs, ICF/DD-Hs, and ICF/DD-Ns,...statewide.
(c) Rural swing-beds...statewide.

J. Special Treatment Program (STP)

For eligible Medi-Cal patients 65 years or older who receive services in an Institution for Mental Disease the STP patch rate will apply. This is a flat add-on rate determined to be the additional cost for facilities to perform these services. STP does not constitute a separate level of care.

II. COST REPORTING

A. All long term-care facilities participating in the Medi-Cal Program shall maintain, according to generally accepted accounting principles, the uniform accounting systems adopted by the State and shall submit cost reports in the manner approved by the State.

1. Cost Reports are due to the State no later than 120 days after the close of each facility's fiscal year (150 days for facilities that are distinct parts of a hospital), in accordance with Medicare and Medi-Cal cost reporting

requirements.

2. Each facility shall 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 shall make such records available upon request to authorized state or federal representatives.

3. All cost reports received by the State shall be maintained for a period of not less than five years following the date of submission of reports, in accordance with 42 CFR 433.32.

4. Cost reports for freestanding facilities shall be included in the rate study even though they may contain more or less than 12 months and/or more than one report, as long as the fiscal periods all end within the time frame specified for the universe being studied. Only cost reports accepted by the Office of Statewide Health Planning and Development (OSHPD) shall be included in the rate study.

5. For DP/NFs and subacute providers, only cost reports formally accepted by the Department with 12 or more months of DP/NF or subacute costs shall be used in the rate study to determine the median facility rate. For purposes of the median determination, only DP/NFs with Medi-Cal patient days accounting for 20 percent or more of their total patient days shall be included.

6. The State reserves the right to exclude any cost report or portion thereof that it deems to be inaccurate, incomplete or unrepresentative.

7. Freestanding STP facilities are excluded from the determination of freestanding NF rates due to their different staffing requirements and the complexity of their reporting costs by level of care and services. The cost reports for these facilities often comingle the data related to NF, Short-Doyle and special county programs.

8. NF Level A rates shall be established on the basis of costs reported by facilities that only provided that level of care during the cost report period.

9. The universe of facilities used to establish the prospective freestanding rates shall be provided by OSHPD on hard copy and tapes. In the case that an error

or oversight is discovered or brought to the State's attention, which would create an inequity, the Department would adjust rates in the following year to compensate providers for the error. Such an adjustment would normally be in the form of an add-on. (See paragraph IV.C, below.)

10. Where identified, facilities that have switched their level of care (e.g., ICF/DD to NF Level B) will not be used to establish rates if their cost report does not reflect their current status.

11. Where identified, facilities that have terminated from the program will be excluded from the rate studies.

12. When ICF/DD-H and N providers erroneously report calendar days instead of patient days on their cost reports, the State will contact the provider for the correct information to be used in the rate study.

B. The Department shall determine reasonable allowable costs based on Medicare reimbursement principles as specified in 42 Code of Federal Regulations (CFR) Part 413. The exceptions to this provision are:

1. The Deficit Reduction Act of 1984 (DEFRA) requires the Department to recognize depreciation only once for reimbursement purposes when a change of ownership has occurred after July 18, 1984. Since the Department reimburses long term care providers using a prospective rate methodology, the Department shall use the net book value approach in lieu of recapturing depreciation to ensure that depreciation is recognized only once for reimbursement purposes. The net book value approach is defined as follows:

   Net book value means that when a change of ownership occurs after July 18, 1984, the asset sold shall have a depreciable basis to the new owner that is the lesser of the: acquisition cost of the new owner; or historical cost of the owner of record as of July 18, 1984, less accumulated depreciation to the date of sale (or in the case of an asset not in existence as of July 18, 1984, the acquisition cost less accumulated depreciation to the date of sale of the first owner of record after July 18, 1984).

2. For developmentally disabled and psychiatric patients in state owned facilities, appropriate personal clothing in lieu of institutional gowns or pajamas are an allowable cost.

3. For purposes of determining reasonable compensation of facility administrators, pursuant to Chapter 9 of the CMS Provider Reimbursement Manual (HIM 15) – reproduced in full at Paragraph 5577 of the CCH Medicare and Medicaid Guide, the State shall conduct its own survey. Based on the data collected from such surveys, the State shall develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those facilities.

   For purposes of this section, "facilities" are defined as: acute care, long term care (skilled nursing, intermediate care, intermediate care for the developmentally disabled, intermediate care for the developmentally disabled habilitative and nursing), Federally Qualified Health Centers, and Rural Health Clinics.

4. (a) Allowable costs shall not include provider expenditures to assist, promote, or deter union organizing to the extent such expenditures are paid by the provider with State funds. Definitions applicable to this paragraph 4 are set forth below in subparagraphs (b) and (c).

   (b) "Assist, promote, or deter union organizing" means any attempt by the provider to influence the decision of its employees in California, or the California employees of its subcontractors, regarding either of the following:

      (i) Whether to support or oppose a labor organization that represents or seeks to represent employees.

      (ii) Whether to become a member of any labor organization.

   (c) "State funds" means California State Treasury funds or California State special or trust funds received by the provider on account of the provider's participation in a California state program. If State funds and other funds are commingled, any expenditures to assist, promote, or deter union organizing shall be allocated between State funds and other funds on a pro rata basis.

   (d) Any costs, including legal and consulting fees and salaries of supervisors and employees, incurred for research for, or preparation, planning, or coordination of, or carrying out, an activity to assist, promote, or deter union organizing shall be treated as paid or incurred for that activity.

(e) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(i) Addressing a grievance or negotiating or administering a collective bargaining agreement.

(ii) Allowing a labor organization or its representatives access to the provider's facilities or property.

(iii) Performing an activity required by federal or state law or by a collective bargaining agreement.

(iv) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

III. AUDITS

A. Except for DP/NFs, subacute, pediatric subacute, transitional inpatient care units, NF-As, ICF/DDs and state-operated facilities, a minimum of 15 percent of cost reports will be field audited by the Department each year. Facilities identified for audit shall be selected on a random sample basis, except where the entire universe of a class is selected for audit. Field audits may be restricted to facilities that have a complete year of reporting. The sample size for each shall be sufficiently large to reasonably expect, with 90 percent confidence, that it will produce a sample audit ratio which varies from the estimated class population audit ratio by not more than two percent. Other facilities may be audited as necessary to ensure program integrity. The results of federal audits, where reported to the State, may also be applied in determining the audit adjustment for the ongoing rate study.

B. The labor data reported by providers shall be audited. In the event that facilities are inconsistently reporting their labor costs in the OSHPD data, the Department will adjust the data utilized to develop the labor index so that the correct amount will be reflected. If the labor data used in developing the labor index is adjusted, the State Plan will be amended to provide the specific methodology for such adjustments.

C. Reports of audits shall be retained by the State for a period of not less than five years, in accordance with 42 CFR 433.32.

D. Providers will have the right to appeal findings which result in an adjustment to program reimbursement or reimbursement rates. Specific appeal procedures are contained in Section 14171 of the Welfare and

Institutions Code, and Article 1.5 (Provider Audit Appeals) of Title 22, California Code of Regulations. See Appendix 2.

E. When facilities being audited have more than one cost report with an end date in the audit year, the last report will be the one audited, except in those cases where a facility-specific audit adjustment will be applied or actual audited costs are used. In these cases, all cost reports with an end date in the audit year will be audited.

F. All state-operated facilities will be subject to annual audits.

G. Cost reports for nursing facilities that are distinct parts of acute care hospitals may be audited annually.

H. All subacute and pediatric subacute providers will be subject to annual audits.

I. All transitional inpatient care units may be subject to annual audits.

IV. PRIMARY REIMBURSEMENT RATE METHODOLOGY

Reimbursement rates shall be reviewed by the Department at least annually. Prospective rates for each class shall be developed on the basis of cost reports submitted by facilities. The following method shall be used to determine rates of reimbursement for a class of facilities when cost reports are available:

A. Audit Adjustment.

1. An audit adjustment shall be determined for each of the following classes:

   (a) NF level B field audited facilities with 1-59 beds.
   (b) NF level A field audited facilities with no bedsize category
   (c) NF level B field audited facilities with 60+ beds.
   (d) ICF/DD field audited facilities with 1-59 beds.
   (e) ICF/DD field audited facilities with 60+ beds.
   (f) ICF/DD-H field audited facilities with combined bedsizes.
   (g) ICF/DD-N field audited facilities with combined bedsizes.

2. Except for DP/NFs and subacute providers, where the audit sample exceeds 80 percent of the universe in a class, the audit adjustment will be applied on a facility-specific basis except that the: (1) class average will be used for unaudited facilities and (2) actual audited costs will be used when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study.

3. For DP/NFs and subacute providers, actual audited costs will be used to determine the facility's prospective rate when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study. If the field audit of the cost report used in the study is not available by July 1, then an interim rate shall be established by applying the field audit adjustment of the NF level Bs with 60+ beds to the cost report. If a facility has an interim reimbursement rate, when the audit report that matches the cost report is issued or the cost report is deemed true and correct under W&I Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to the beginning of the rate year to reflect these costs, not to exceed the maximum rate as set forth in Section IV.E. Interest shall accrue and be payable on any underpayments or overpayments resulting from such adjustment. Medicare standards and principles of cost reimbursement shall be applied when auditing DP/NFs (see 42 CFR Part 413).

4. As a result of the appeal process mentioned in III.D., some audit findings may be revised. Except for DP/NFs and subacute, the audit adjustment for the current year shall incorporate any revisions resulting from a decision on an audit appeal. The Department shall consider only the findings of audit appeal reports that are issued more than 180 days prior to the beginning of the new rate year.

   For DP/NFs or subacute providers, excluding pediatric subacute, that obtain an audit appeal decision that the facility-specific audit adjustment on which a DP/NF or subacute rate is based inaccurately reflects the facility's projected costs, the facility shall be entitled to seek a retroactive adjustment in their prospective reimbursement rate, not to exceed the maximum DP/NF or subacute rate, as set forth under Section IV (E)(1), (10) and (11).

5. Audited costs will be modified by a factor reflecting share-of-cost overpayments in the case of class audit adjustments.

6. The results of federal audits, when reported to the state, may be applied in determining audit adjustments.

B. Adjustment for facilities which provide a different type of service from the remainder of the class.

Additional amounts, where appropriate, shall be added to the payment rates of individual facilities in a class to reimburse the costs of meeting

requirements of state or federal laws or regulations including the costs of special programs.

C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal laws and regulations which would impact upon such costs. These adjustments will be reflected as an "add-on" to the rates for these costs and, where appropriate, an "add on" may be used to reflect other extraordinary costs experienced by intermediate care facilities for the developmentally disabled (including habilitative and nursing facilities for the developmentally disabled). Add ons for extraordinary costs shall not be considered for other categories of long term care providers. To the extent not prohibited by federal law or regulations, "add-ons" to the rate may continue until such time as those costs are included in cost reports used to set rates under this state plan.

For example, state or federal mandates may include such costs as changes to the minimum wage or increases in nurse staffing requirements. An example of other extraordinary costs might include unexpected increases in workers compensation costs or other costs which would impact facilities ability to continue to provide patient care.

A brief description of all add-ons included in the current year's rate study will be provided to HCFA by December 31st of the rate year, as a part of Supplement 1.

D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.
2. An index developed from the most recent historical data in the long term care industry as reported to OSHPD by providers.

The update factors used by the Department shall be applied to all classes from the midpoint of each facility's fiscal period to the midpoint of the State's rate year in which the rates are effective.

E. Cost-of-Living Update

Adjusted costs for each facility are updated from the midpoint of the facility's report period through the midpoint of the State's Medi-Cal rate year

Adjusted costs are divided into categories and treated as follows:

1. Fixed or Capital-Related Costs - These costs represent depreciation, leases and rentals, interest, leasehold improvements, and other amortization. No update is applied.

2. Property Taxes - These costs, where identified, are updated at a rate of 2 percent annually, converted to 0.1652 percent per month. Some facilities do not report property taxes---either because they are nonprofit and exempt from such tax or because they have a lease or rental agreement that includes those costs.

3. Labor Costs - A ratio of salary, wage, and benefits (SWB) costs to the total costs of each facility is used to determine the amount of the labor cost component to be updated. The ratio is determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report, and adding costs that represent all wage-related benefits, including vacation and sick leave.

   The labor costs for ICF/DD-Hs and ICF/DD-Ns are facility-specific, obtained directly from each cost report in the study. Labor costs for each facility are updated from the midpoint of its cost reporting period to the midpoint of the State's rate year.

4. All Other Costs - These costs are the total costs less fixed or capital-related costs, property taxes, and labor costs. The update for this category utilizes the California Consumer Price Index (CCPI) for "All-Urban Consumers" and figures projected by the State Department of Finance.

F. The reimbursement rate per patient day shall be set at the median of projected costs for the class, as determined above, except that:

1. NF-B services, excluding subacute and pediatric subacute, which are provided in distinct parts of acute care hospitals, shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate.

2. NF-A services provided in distinct parts of acute care hospitals shall be reimbursed at the applicable NF-A rate for freestanding facilities in the same geographical area location.

3. Rural hospitals are identified each year by OSHPD. For those rural hospitals with Medi-Cal distinct part nursing facility days, their rates, as determined for the DP/NF-B level of care, are arrayed and the median rate is applied to all rural swing bed days. Facilities that report no Medi-Cal days, have an interim rate, or

submit only a partial year cost report are excluded from the swing bed rate calculation.

4. NF services provided in a facility which is licensed together with an acute care hospital under a single consolidated license, yet fails to meet the definition of a DP/NF, shall be reimbursed at the applicable rate for freestanding facilities.

5. As long as there is a projected net increase in the California Consumer Price Index during the State's fiscal year previous to the new rate year, no prospective rate of reimbursement shall be decreased solely because the class median projected cost is less than the existing rate of reimbursement. In the event the existing prospective class median is adopted as the maximum reimbursement rate for DP/NF-Bs and subacute units providers with projected costs below the existing class median shall be reimbursed their projected costs as determined in the most recent rate study.

   In the event there are components in the previous rate study that increased the reimbursement rate to compensate for time periods prior to the effective date of the rates, the rates shall be adjusted (for purposes of determining the existing rate) to reflect the actual per diem cost without the additional compensation. As an example, assume that the per diem cost of a new mandate was $.10. The new mandate was effective June 1, 1997, but the rates were not implemented until August 1, 1997. The rates would include an add-on of $.117 ($.10 times 14 months, divided by 12 months) to compensate 14 months add-on over a 12 month rate period.

6. If a DP, formerly licensed as a freestanding facility, has costs less than the freestanding median rate for their group, their rate will not be reduced to less than the median solely because of the change to distinct part licensure.

7. DPs in areas where there are excess freestanding beds may accept patients at the area's highest NF-B rate to assure greater access to Medi-Cal patients and to provide a savings to the program.

8. State operated facilities shall be reimbursed their costs as reflected in their cost reports, in accordance with the provisions of this plan, using individual audit data for adjustments. These costs are not to be included in the calculation of the class median rate for all other DP/NF level Bs.

9. ICF/DDs (except state operated facilities), ICF/DD-H and ICF/DD-N facilities will be reimbursed at the 65th percentile, instead of the median, in recognition of the fact that they serve a disproportionate share of low income patients with special needs.

10. Subacute services which are provided in both distinct parts of acute care hospitals and freestanding NFs shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate, broken down by ventilator and non-ventilator and DP or freestanding NF.

11. The subacute rate includes additional ancillary costs. Where available, the facility's projected cost is based on the audited ancillary cost data. In the event that audited ancillary costs are not available, the facility's projected cost is based on the median of the projected subacute ancillary costs of the facilities in the study that have audited ancillary costs.

12. For purposes of setting the DP/NF or subacute prospective class median rate, the Department shall use the facility's interim projected reimbursement rate when their audit report is not issued as of July 1st.

13. (a) For the rate year 2002-03, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2002-03 rate year, had its subacute prospective reimbursement rate for 2002-03 set at its 2001-02 rate. The facility's 2002-03 subacute prospective reimbursement rate was no more than the 2002-03 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

(b) For the rate year 2003-04, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2003-04 rate year, had its subacute prospective reimbursement rate for 2003-04 set at its 2002-03 rate. The facility's 2003-04 subacute prospective reimbursement rate was no more than the 2003-04 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

(c) For the rate year 2005-06, and each rate year thereafter, a DP/NF subacute facility that experiences a reduction in costs in the previous rate year, which would result in a reduced reimbursement rate for the current rate year, will have its prospective reimbursement rate for the current rate year established at the reimbursement rate for the previous rate year. For example, if a DP/NF subacute facility's 2006-07 prospective reimbursement rate was less than the DP/NF subacute's 2005-06 prospective reimbursement rate, the DP/NF subacute's reimbursement rate for the 2006-07 rate year will be established at its 2005-06 prospective reimbursement rate This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

14. Any facility that has been a NF-A 100+ bedsize facility will no longer have its reimbursement rate adjusted at the same percentage increase as other NF-level As. Its reimbursement rate will be based on the applicable methodology described in this Section IV paragraph F.

15. (a) Nursing facilities and other specified facilities as identified in Section 14110.65 of the Welfare and Institutions Code, will be eligible to request and receive a supplemental rate adjustment when the facility meets specific requirements.

(b) In order to qualify for the rate adjustment, the facility must have a verifiable written collective bargaining agreement or other legally binding, written commitment to increase non-managerial, non-administrative. and non-contract salaries, wages and/or benefits that complies with Section 14110.65 of the Welfare and Institutions Code and regulations adopted pursuant thereto.

(c) Except as provided in subparagraph (d) below, the rate adjustment will be equal to the Medi-Cal portion (based on the proportion of Medi-Cal paid days) of the total amount of any increase in salaries, wages and benefits provided in the enforceable written agreement referenced in subparagraph (b). This amount will be reduced by an increase, if any, provided to that facility during that rate year in the standardized rate methodology for labor related costs (see Section I.E of this state plan) attributable to the employees covered by the commitment. A rate adjustment made to a particular facility pursuant to this subparagraph 15 will only be paid for the period of the non-expired, enforceable, written agreement. The Department will terminate the rate adjustment for a specific facility if it finds the binding written commitment has expired and does not otherwise remain enforceable.

(d) A rate adjustment under this subparagraph 15 will be no more than the greater of 8 percent of that portion of the facility's per diem labor costs, prior to the particular rate year (August 1st through July 31st), attributable to employees covered by the written commitment, or 8 percent of the per diem labor costs of the peer group to which the facility belongs, multiplied by the percentage of the facility's per diem labor costs attributable to employees covered by the written commitment.

(e) The payment of the rate adjustment will be subject to certification of the availability of funds by the State Department of Finance by May 15 of each year and subject to appropriation of such funds in the State's Budget Act.

(f) This subparagraph 15 will become effective as of the first day of the month following the date that this provision is approved by the Centers for Medicare and Medicaid Services.

16. (a) Hospice care rates apply to four basic levels of care: Routine Home Care, Continuous Home Care, Inpatient Respite Care, and General Inpatient Care. Each year after the end of the Federal fiscal year (September 30), the Centers for Medicare & Medicaid Services provides the Department of Health Services with the new Medicare rates and the wage indices for the various groupings of California counties. Each Medicare rate for the services referenced above consists of a wage and non-wage component. The wage component of each Medicare rate is multiplied by the wage index for each county grouping and the result is added to the non-wage component to arrive at the reimbursement rate for hospice care services rendered within the particular county grouping. These rates are effective from October 1 through September 30 of each year.

(b) Effective January 3, 2004, in addition to the reimbursement for the services referenced in (a) above, payment to facilities for room and board services shall be made at 95 percent of the Medi-Cal facility rate where the patient resides, if the facility is classified as one of the following: Nursing Facility Level B, Nursing Facility Level A, Intermediate Care Facility – Developmentally Disabled, Intermediate Care Facility – Developmentally Disabled, Habilitative, Intermediate Care Facility – Developmentally Disabled, Nursing.

G. Notwithstanding paragraphs A through E of this Section, in the five situations described below, DP/NF-Bs will receive an interim per diem rate established by the Department. The interim rate will be based on the DP/NF-B's estimate of its total patient days and costs, including the patient days and costs associated with the additional beds that are added. The interim rate established by the Department will not exceed the applicable DP/NF-B median rate for the particular rate year. This provision applies to the following situations:

1. A general acute care hospital (GACH) without a DP/NF-B acquires a previously licensed freestanding NF-B and converts it to newly approved DP/NF-B.
2. A GACH with a DP/NF-B merges with another GACH with a DP/NF-B and consolidates all beds under one existing license.
3. A GACH with a DP/NF-B consolidates a freestanding NF-B into one existing license.
4. Any instance, which results in the creation of a Composite DP/NF-B, as defined in 42 Code of Federal Regulations section 483.5(c) which refers to a facility with one license, one provider agreement, and one provider number.
5. A GACH forms a newly licensed DP/NF-B.

The interim per diem rate and supplementation under Section VIII will be effective upon the date the Department issues a consolidated license or adds the additional beds to the hospital's current license. When DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-B's final

2. A GACH with a DP/NF-B merges with another GACH with a DP/NF-B and consolidates all beds under one existing license.

3. A GACH with a DP/NF-B consolidates a freestanding NF-B into one existing license.

4. Any instance, which results in the creation of a Composite DP/NF-B, as defined in 42 Code of Federal Regulations section 483.5(c) which refers to a facility with one license, one provider agreement, and one provider number.

Newly licensed DP/NF-Bs without historical costs of providing NF-B services shall receive an interim reimbursement rate. This interim rate shall be based on the DP/NF-B's projection of their total patient days and costs, as approved by the Department. When actual DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-Bs final prospective rate. Final DP/NF-B rates may be less than the interim rate, in which case the Department shall recover any overpayment.

H. DP/NF subacute providers that do not have historical costs shall receive an interim reimbursement rate. This interim rate shall be based on the facility's projection of their total patient days and costs, as approved by the Department. When twelve or more months of actual DP/NF subacute audit report data becomes available, interim rates will be retroactively adjusted to the facility's final prospective rate. Final rates may be less than the interim rate, in which case the Department shall recover any overpayment. Only DP/NF subacute providers participating in the program as of June 1st will be included in the rate study.

I Notwithstanding Paragraphs A. through G. of this Section, San Mateo County Hospital shall receive an interim reimbursement rate for the skilled nursing facility located at 1100 Trousdale Drive in Burlingame, California. The interim rate will be effective on August 1, 2003 and will be equal to the hospital DP/NF rates of its existing DP/NF skilled nursing facility located at 222 West 39th Avenue in San Mateo, California. The interim rate will apply through July 31, 2006.

J. In accordance with Section 14105.06 of the Welfare and Institutions Code and notwithstanding paragraphs A through F of this Section, all Medi-Cal long-term care facility rates that went into effect August 1, 2003, will remain unchanged through July 31, 2005, and be in effect for the period August 1, 2003, through July 31, 2005. This provision applies to all long-term care facility types (except those operated by the State), including the following:

1. Freestanding nursing facilities licensed as either of the following:

(a) An intermediate care facility pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(b) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code.

2. A skilled nursing facility that is a distinct part of a general acute care hospital as defined in Section 72041 of Title 22 of the California Code of Regulations.

3. A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.

K. Unless otherwise specified in this Section K, the facility types listed below will be reimbursed at the prospective rate for services provided in the particular rate year. The tables below reflect rate reductions at specified percentages (or rates that remain unchanged) with respect to the prospective rate applicable for the particular time period. "Prospective rate" means the prospective rate established for a given rate year in accordance with this Part IV (and other provisions of this Attachment, as applicable). Reductions specified below will only be applied for the dates listed.

1. Nursing Facilities – Level A (NF-A)

Nursing Facilities Level A		
Period	Reduction	With Respect to:
07/01/08 - 07/31/08	10%	Prospective rate for 2007/08
08/01/08 - 02/28/09	10%	Prospective rate for 2008/09
03/01/09 - 05/31/11	5%	Prospective rate for 2008/09
06/01/11 - Present	10%	Prospective rate for 2008/09

2. Skilled Nursing Facilities that are Distinct parts of General Acute Care Hospitals – Level B (DP/NF–B)

Distinct Part Nursing Facilities Level B		
Period	Reduction	With Respect to:
07/01/08 - 07/31/08	10%	Prospective rate for 2007/08
08/01/08 - 02/28/09	10%	Prospective rate for 2008/09
03/01/09 - 04/05/09	5%	Prospective rate for 2008/09
08/01/09 - 02/23/10	Set at Prospective rate for 2008/09	
03/01/11 - 05/31/11	5%	Prospective rate for 2008/09
06/01/11 - Present	10%	Prospective rate for 2008/09

a. A Distinct Part Nursing Facility – Level B (DP/NF-B) is exempt from the reductions set forth in this Paragraph 2 and in subdivision (j) of Section 14105.192 of the California Welfare and Institutions (W&I) Code as in effect on June 28, 2011, on and after February 18, 2012, if the facility provides services to patients, 90 percent or more of whom are under 21 years of age at the time services are rendered.

For each State Plan Rate Year (as described in paragraph E of Section I at page 3 of this Attachment), the State will review the most recent Audits and Investigations Audit Report, used for rate setting, for total Pediatric Bed Days to identify those facilities that met the criteria stated above. If a facility is determined to meet the criteria, it will be exempt from the rate reduction for the given rate year.

b. On or after September 1, 2013, a DP/NF-B, designated as rural or frontier, is exempt from the reductions set forth in this Paragraph 2 and subdivision (j) of Section 14105.192 of the W&I Code as in effect on June 28, 2011.

For purposes of this exemption, a provider is designated as rural if the provider has been determined to be rural by the Office of Statewide Health Planning & Development (OSHPD) using Hospital Annual Utilization Data (HAUD) and identified rural Medical Study Services Area (MSSA) data. A provider is designated as frontier if the provider has been determined to be frontier by OSHPD using HAUD and identified frontier MSSA data.

c. On or after October 1, 2013, every DPNF-B, in addition to the rural and frontier DP/NF-Bs indicated above, is exempt from the reductions set forth in this Paragraph 2 and subdivision (j) of Section 14105.192 of the W&I Code as in effect on June 28, 2011.

3. Subacute Care Units that are, or are parts of, Distinct Parts of General Acute Care Hospitals (DP/NF Subacute)

Distinct Part Adult Subacute		
Period	Reduction	With Respect to:
07/01/08 - 07/31/08	10%	Prospective rate for 2007/08
08/01/08 - 02/28/09	10%	Prospective rate for 2008/09
03/01/09 - 04/05/09	5%	Prospective rate for 2008/09
08/01/09 - 02/23/10	Set at Prospective rate for 2008/09	

4. Freestanding Pediatric Subacute Care Unit

Freestanding Pediatric Subacute		
Period	Reduction	With Respect to:
08/01/09 - Present	Set at Prospective rate for 2008/09	

5. Pediatric Subacute Care Units that are, or are parts of, Distinct Parts of General Acute Hospitals (DP/NF Pediatric Subacute)

Distinct Part Pediatric Subacute		
Period	Reduction	With Respect to:
07/01/08 - 07/31/08	10%	Prospective rate for 2007/08
08/01/08 - 02/28/09	10%	Prospective rate for 2008/09
03/01/09 - 04/05/09	5%	Prospective rate for 2008/09
08/01/09 - 02/23/10	Set at Prospective rate for 2008/09	

6. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)

ICF/DD		
Period	Reduction	With Respect to:
08/01/09 - Present	Set at Prospective rate for 2008/09	

7. Intermediate Care Facilities for the Developmentally Disabled – Habilitative (ICF/DD-H)

ICF/DD - H		
Period	Reduction	With Respect to:
08/01/09 - Present	Set at Prospective rate for 2008/09	

8. Intermediate Care Facilities for the Developmentally Disabled – Nursing (ICF/DD-N)

ICF/DD - N		
Period	Reduction	With Respect to:
08/01/09 - Present	Set at Prospective rate for 2008/09	

9. Rural Swing Bed

Rural Swing Bed		
Period	Reduction	With Respect to:
07/01/08 - 07/31/08	10%	Prospective rate for 2007/08
08/01/08 - 10/31/08	10%	Prospective rate for 2008/09
08/01/09 - 02/23/10	Set at Prospective rate for 2008/09	
03/01/11 - Present	Set at Prospective rate for 2008/09	

L. The payment reductions in boxes (1) through (9) will be monitored in accordance with the monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services".

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.

6. Overpayments to any ICF/DD, ICF/DD-H, and ICF/DD-Ns will be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations. Overpayment recovery regulations are described in the California Code of Regulations, Title 22, Section 51047, as in effect on August 1, 2012.

7. Providers have the right to appeal audit or examination findings that result in an adjustment to Medi-Cal reimbursement rates. Specific appeal procedures are contained in Welfare and Institutions Code, Section 14171, as in effect on August 1, 2012, and in Division 3, Subdivision 1, Chapter 3, Article 1.5 (Provider Audit Appeals) of the California Code of Regulations, Title 22, Sections 51016 through 51048, as in effect on August 1, 2012.

8. New ICF/DD, ICF/DD-H, and ICF/DD-Ns with no cost history in a newly constructed facility, in a location not previously licensed as an ICF/DD, ICF/DD-H, or ICF/DD-N, or an existing facility newly certified to participate in the Medi-Cal Program will receive interim reimbursement at a rate equal to the 2008-09 65th percentile rate for the applicable peer group (licensed facility type and bedsize category). In these circumstances, DHCS will request an audit of the cost report period in which the State issued the new license. At such time that the audit report data reflecting at least six months or more becomes available, the interim rate will be retroactively adjusted to a final rate based on the current methodology.

9. In instances where an existing facility which has participated in the Medi-Cal Program changes ownership or operators, DHCS will reimburse the facility an interim per diem payment rate at the 2008-09 65th percentile of the applicable peer group. The provider will continue to receive the 2008-09 65th percentile at the respective peer group until the new owner or operator has submitted six or more months of Medi-Cal cost and/or supplemental data and DHCS has audited these costs. At such time the audit report data becomes available, the interim rate will be retroactively adjusted to the appropriate final rate based on the current methodology.

10. If any ICF/DD, ICF/DD-H, or ICF/DD-N provider does not complete and submit a cost report for computing the projected cost per day for the upcoming rate year, that provider will receive a rate at the 2008-09 65th percentile established for the peer group in which that provider belongs, reduced by 10 percent. Once a provider submits a cost report applicable to the rate year in which its costs would be used in the calculation of its projected cost per day, DHCS will calculate an individual rate based on the current methodology, and apply that rate retroactively for the rate period.

11. The effect of the reduction specified in paragraph M.1 will be monitored in accordance with the access monitoring plan in Attachment 4.19-F.

12.a. Notwithstanding Sections III.A, IV.A.I and IV.A.2 of this Attachment (at pages 9 and 10), effective with the 2012-13 rate year, DHCS will use audited costs in determining rates for those facilities which were audited, and will apply the ICF/DD-H and ICF/DD-N audit adjustment factors (as described in Section IV.A) to facilities which were not audited.

b Notwithstanding Sections III.A, IV.A.I, IV.A.2, and IV.M.12.(a) of this Attachment (at pages 9, 10, and 15.4c.3), beginning with the 2013-14 rate-year, DHCS will use facility-specific audited costs to calculate the rates for audited facilities.

DHCS will use reported costs to calculate the rates for those facilities which were not audited. Beginning with the 2013-14 rate-year, the ICF/DD, ICF/DD-H, and ICF/DD-N audit adjustment factors (as described in Section IV.A) will not be applied.

DHCS will audit one hundred percent of ICF/DD facilities. ICF/DD-H and ICF/DD-N facilities to be audited will be selected on the basis of reported and projected costs, and will include those facilities which would be adversely impacted under the rate methodology detailed in Section IV.M of this Attachment, if the audit adjustment factors (as described in Section IV.A), are 10% or less.

ICF/DD-H and ICF/DD-N facilities will not be selected for an audit if their reported and projected costs are low or high enough that the minimum or maximum rate would still be assigned with an audit adjustment factor up to and including 10%. This audit range takes into consideration the 5% increase per paragraph M.1 of this Section.

13.a (i) In the event that DHCS determines, pursuant to subparagraph M.13.b, that reduced per-diem reimbursement rates calculated using the methodology specified in subparagraph M.1 may be insufficient to enlist or maintain participation of providers of ICF/DD services, DHCS will institute a per-diem rate for a 120 day review period for facilities statewide that will be equal to the per-diem reimbursement rates in effect for the 2008-09 rate-year. DHCS may adjust the per-diem rate for one or more mandates that are applicable to the providers of ICF/DD services.

(ii) In the event that DHCS determines, pursuant to subparagraph M.13.b, that reduced per-diem reimbursement rates calculated using the methodology specified in subparagraph M.1 may be insufficient to enlist or maintain participation of providers of ICF/DD-H or ICF/DD-N services, DHCS will institute a per-diem rate for a 120 day review period for facilities in a geographic area (as defined in paragraph 13.d) that will be equal to the per-diem reimbursement rates in effect for the 2008-09 rate year.

DHCS may adjust the per-diem rate for one or more mandates that are applicable to the providers of ICF/DD-H or ICF/DD-N services.

b. The determination described in subparagraphs M.13.a(i) and M.13.a(ii) will be made when the number of licensed beds decreases by 5 percent or more, relative to when the per-diem reimbursement rate decrease took effect, in either of the following:

- ICF/DDs statewide, if the total resident occupancy level statewide is equal to or in excess of 98 percent.
- An ICF/DD-H or ICF/DD-N geographic area (as defined in paragraph 13.d) where the total resident occupancy level is equal to or in excess of 98 percent.

The number of licensed beds will be measured on an ongoing basis, and the occupancy levels will be measured on a quarterly basis in accordance with the DHCS' monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services".

c. The 120-day review period will begin on the date that DHCS notifies CMS of its intention to increase the rate. DHCS will also notify the affected providers of the effective date of the rate increase, and will provide the data that triggered the rate change.

d. A geographic area is defined as a geographic peer-group for purposes of this Paragraph M. A listing of the counties comprising each geographic peer-group can be found in Section V, at page 18 of Supplement 4 to Attachment 4.19-D.

e. In conjunction with the reinstatement of per-diem reimbursement rates to the 2008-09 levels for a given geographic peer-group for ICF/DD-H and ICF/DD-N, and ICF/DD statewide, DHCS shall have a period of 120 days to conduct an analysis of the extent to which reduced per-diem reimbursement rates may have resulted in the decrease in the number of licensed beds. Once DHCS has concluded its analysis, it shall notify Centers for Medicare & Medicaid Services' Regional Office and affected providers of its final determinations and provide the data in support of DHCS' analysis and conclusion. DHCS will then take one of the following actions:

(i) Restore the reduced per-diem reimbursement rates previously in effect, because DHCS' analysis determined that the decrease in the number of licensed beds was not related to the reduced per-diem reimbursement rates.

(ii) Submit another SPA within the next 90 days following the initial 120 days to adjust the per-diem reimbursement rates. The higher rates paid under paragraphs 13.a(i) and (ii) shall remain in effect as the reimbursement rates up to the effective date of the new SPA. The higher rates paid under paragraphs 13.a(i) and (ii) shall also continue to be paid, as interim rates, from the effective date of that new SPA until that SPA is approved; the rates approved under the new SPA will then be retroactively applied back to the effective date of that SPA.

f. The effective date for making the determination set forth in subparagraph 13.b will be based on the effective date of SPA 11-010B (that is August 1, 2012). For purposes of this determination, each facility category as identified in subparagraphs 13.a(i) and 13.a(ii) will be examined separately.

g. The reimbursement rates resulting from the application of this Paragraph M.12 will be published on the DHCS website at the following link: http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx.

V. DETERMINATION OF RATES FOR NEW OR REVISED PROGRAMS

A. When State adopts a new service or significantly revises an existing service, the rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.

B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study. After five years from the end of the fiscal year in which a facility begins participating in a program for Medi-Cal reimbursement, the reimbursement rate methodology will either revert to the provisions described in Section I through IV of Attachment 4.19 – D or be subject to new provisions as described in a State Plan Amendment.

VI. DP/NF SERVICES SUPPLEMENTAL REIMBURSEMENT PROGRAM

This program provides supplemental reimbursement for a DP/NF of a general acute care hospital or an acute psychiatric care hospital, which meets specified requirements and provides a large proportion of nursing facility services to Medi-Cal beneficiaries.

Supplemental reimbursement is available for the costs associated with the construction, renovation, expansion, remodel, or replacement of an eligible facility, and would be in addition to the rate of payment the facility receives for nursing facility services under the current DP/NF reimbursement methodology.

A. Definition of an Eligible Project

1. Projects eligible for supplemental reimbursement under this program will include any new capital projects for which final plans have been submitted to the appropriate review agency after January 1, 2000, and before July 1, 2001, or as permitted by subsequent legislation that changes the final plan submission date.

2. "Capital project" means the construction, expansion, replacement, remodel, or renovation of an eligible facility, including buildings and fixed equipment. A "capital project" does not include furnishings or items of equipment that are not fixed equipment.

3. Capital projects receiving funding under this program will include the upgrade or construction of buildings and equipment only to a level required by the most current accepted medical practice standards, including projects designed to correct Joint Commission on Accreditation of Hospitals and Health Systems, fire and life safety, seismic, or other federal and state related regulatory standards.

B. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity had all of the following additional characteristics during the entire 1998 calendar year:

1. Provided services to Medi-Cal beneficiaries;
2. Was a DP/NF of an acute care hospital providing nursing facility care;

3. Had not less than 300 licensed nursing facility beds;
4. Had an average nursing facility Medi-Cal patient census of not less than 80 percent of the total nursing facility patient days; and
5. Was owned by a county, or city and county.

C. Supplemental Reimbursement Methodology

Supplemental reimbursement provided by this program will be distributed under a payment methodology based on nursing facility services provided to Medi-Cal patients at the eligible facility. An eligible facility's supplemental reimbursement for a capital project qualifying for this program will be calculated and paid as follows:

1. For any fiscal year the facility is eligible to receive supplemental reimbursement, the facility will report to the Department the amount of debt service on the revenue bonds or other financing instruments issued to finance the capital project. This amount represents the gross total amount to be considered for supplemental reimbursement. The gross total amount will be reduced by all other funds received by an eligible county or city and county for the purpose of construction/renovation of an eligible project.

2. Only those projects, or portions thereof, that are available and accessible to Medi-Cal beneficiaries will be considered for supplemental reimbursement, and such supplemental reimbursement will only be made for capital projects, or for that portion of capital projects, which provide nursing facility services and qualifies for reimbursement according to applicable Medicare reimbursement principles.

   Capital project expenditures for an eligible facility are those expenditures which, under generally accepted accounting principles, are not properly chargeable as expenses of operation and maintenance and are related to the acquisition, construction, renovation, improvement, modernization, expansion, or replacement of a plant, buildings, and equipment with respect to which the expenditure is made, including, but not limited to the following, if included in revenue bond debt service: (1) studies, surveys, designs, plans, working drawings, and specifications bid preparation, inspection, and material testing; (2) site preparation, including demolishing or razing structures, hazardous waste removal, and grading and paving; and (3) permit and license fees.

3. For each fiscal year in which an eligible facility requests reimbursement, the Department will establish the ratio of nursing facility Medi-Cal days of care provided by the eligible facility to total nursing facility patient days of care provided by the eligible facility. The ratio will be established using the most current Medi-Cal data obtained from audits performed by the Department. This ratio will be applied to the corresponding fiscal year of debt service on the revenue bonds or other financing instruments used to finance the capital project.

4. The amount of debt service submitted to the Federal Health Care Financing Administration for the purpose of claiming reimbursement for each fiscal year will equal the amount determined annually in paragraphs 1 and 2, multiplied by the percentage figure determined in paragraph 3.

For example:

- Eligible Debt Service (paragraphs 1 and 2) $1,000,000
- Annual Ratio (paragraph 3) $\frac{75}{100}$ (Total nursing facility Medi-Cal days) (Total nursing facility patient days) = .75

$1,000,000 x .75 = $750,000

The resulting net amount (i. e. $750,000) will be claimed at the applicable federal Medicaid assistance percentage for each fiscal year it is submitted.

D. Facility Reporting Requirements

1. An eligible facility must submit documentation to the Department regarding debt service on revenue bonds or other financing instruments used for financing the capital project. This documentation includes, but is not limited to, a copy of the initial financing instrument that has funded an eligible capital project and any refinancing.

2. To meet the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, the county, or city and county, for any eligible facility, is required to certify (in the manner specified by the Department) that the

claimed expenditures for the capital project are eligible for federal financial participation.

3. In order to fully disclose reimbursement amounts to which the eligible facility may be entitled, the county, or city and county is required to keep, maintain, and have readily retrievable, records as specified by the Department. Such records include, but are not limited to, construction and debt service costs.

4. Prior to receiving supplemental reimbursement an eligible hospital must submit to the Department a copy of the certificate of occupancy for the capital project.

5. Prior to paying any supplemental reimbursement, the Department will require the county, or city and county, to disclose all public and private funds it receives for the purpose of financing the capital project.

6. Any and all funds expended pursuant to this program are subject to review by the Department. The Department will review, on a semiannual basis, the special account where all payments received by an eligible facility are placed and used exclusively for the debt service on an eligible project to verify that funds are used exclusively for the payment of appropriate expenses related to the eligible capital project.

E. Standards for Supplemental Reimbursement

1. The Department will require that any county, or city and county, receiving supplemental reimbursement under this program enter into a written interagency agreement with the Department for the purpose of implementing this program.

2. Supplemental reimbursement paid under this program must not duplicate any reimbursement received by an eligible facility for construction costs that would otherwise be eligible for reimbursement for nursing facility services under the DP/NF reimbursement methodology specified in this Attachment.

3. The total Medi-Cal reimbursement received by a facility eligible under this program will not result in a reduction of the rate of payment the facility

receives for nursing facility services under the most current DP/NF reimbursement methodology.

4. The supplemental reimbursement provided by this program will not commence prior to the date the hospital submits to the Department a copy of the certificate of occupancy for the capital project.

5. All payments received by an eligible facility must be placed in a special account; the funds in the special account will be used exclusively for the payment of expenses related to the eligible capital project.

6. Supplemental reimbursement will be equal to the amount of federal financial participation received for the claims submitted by the Department for debt service expenditures allowable under federal law.

7. In no instance will the total amount of supplemental reimbursement received under this program combined with that received from all other sources dedicated exclusively to debt service, exceed 100 percent of the debt service for the capital project over the life of the loan, revenue bond, or other financing mechanism.

8. A facility qualifying for and receiving supplemental reimbursement pursuant to this program will continue to receive reimbursement: (i) until the qualifying loan, revenue bond, or other financing mechanism is paid off; and (ii) as long as the facility's eligible capital project continues to provide nursing facility services and is available and accessible to Medi-Cal patients.

9. The state share of the debt service amount submitted to the Federal Health Care Financing Administration for purposes of supplemental reimbursement will be: (i) paid with only county, or only city and county funds; and (ii) certified to the state as specififed in paragraph D. 2. above.

10. Total Medicaid reimbursement provided to an eligible facility will not exceed applicable federal upper payment limits.

VII. PUBLIC CONSIDERATION

A. A public comment period is provided, during which a public hearing may be requested by interested parties. During this period, the evidentiary base and a report of the study methodology and findings are available to the public.

1. Interested parties will be notified of the time and place of the hearing (if scheduled), and the availability of proposed rates and methodologies by direct mail and public advertising in accordance with state and federal law.
2. Comments, recommendations, and supporting data will be received during the public comment period and considered by the Department before certifying compliance with the state Administrative Procedures Act.
3. As part of the final regulation package, the Department will respond to all comments received during the public comment period concerning the proposed changes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

VIII. PUBLIC HOSPITAL DISTINCT PART NURSING FACILITY SUPPLEMENTAL REIMBURSEMENT

This segment of the State Plan describes supplemental reimbursement for a distinct part nursing facility level B (DP/NF-B) of a general acute care hospital that is owned or operated by a city, city and county, or health care district, which meets specified requirements and provides skilled nursing services to Medi-Cal beneficiaries.

Supplemental reimbursement under this segment of the State Plan is available for allowable costs that are in excess of the rate of payment the facility receives for nursing facility services under the current DP/NF-B reimbursement methodology, as specified in Sections I through V in this Attachment 4.19-D, and any other source of Medi-Cal reimbursement for DP/NF-B services.

A. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity continuously has all of the following characteristics during the Department of Health Care Services' (DHCS') rate year beginning August 1, 2012, and subsequent rate years:

1. Provides skilled nursing services to Medi-Cal beneficiaries.

2. Is a DP/NF-B of an acute care hospital, as it was defined on August 1, 2012, in Health and Safety Code Section 1250 subdivision (a) or (b), or both.

3. Is owned or operated by a city, county, city and county, and/or health care district organized pursuant to Chapter 1 of Division 23 (commencing with section 32000) of the Health and Safety Code as those terms are defined as of August 1, 2012.

B. Supplemental Reimbursement Methodology

1. The expenditures reported to DHCS by the facility represent the allowable and otherwise uncompensated, costs incurred for the provision of covered DP/NF-B services to Medi-Cal beneficiaries. Such costs are based on the cost reporting form CMS-2552. The facility will use the CMS-2552 to determine total allowable cost and apportion that cost to Medi-Cal services in accordance with the established CMS-2552 apportionment methodology. For each facility, the net Medi-Cal expenditures which may be certified to DHCS for purposes of claiming FFP pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations (CFR) is the total allowable Medi-Cal uncompensated cost as determined pursuant to Paragraph B.

2. Total computable expenditures submitted for purposes of claiming FFP (which constitutes the supplemental reimbursement under this segment) may not be greater than the difference between total allowable cost for Medi-Cal covered skilled nursing services and the amount paid under the existing DP/NF-B reimbursement methodology specified in Sections I through V in this Attachment 4.19-D.

3. The total Medi-Cal expenditures certified for reimbursement by a facility eligible for supplemental reimbursement, when combined with the amount received from other sources of payment for covered Medi-Cal skilled nursing facility services will in no instance exceed 100 percent of costs for covered Medi-Cal DP/NF-B services at each facility. Covered Medi-Cal DP/NF-B services do not include those services that are separately reimbursed outside of the rate methodology described in Sections I through V of this Attachment 4.19-D for DP/NF-Bs.

4. Costs associated with the provision of subacute services pursuant to Section 14132.25 of the California Welfare and Intuitions Code will not be certified for reimbursement under this segment.

5. After DHCS receives the FFP pursuant to the claiming methodology described in this segment of the State Plan (based on the certified public expenditures), those FFP amounts will be transmitted to the eligible governmental entity. DHCS will make no other payments pursuant to this segment of the State Plan.

C. Facility Reporting Requirements

The governmental entity reporting with respect to any eligible facility will do all of the following:

1. Certify that the claimed expenditures for skilled nursing services are eligible for FFP pursuant to Section 433.51 of Title 42 of the CFR.

2. Provide DHCS with reliable data for the computation of the facility's net allowable costs and a certification that states that the amount submitted by them is eligible for FFP.

3. Submit data, as specified by DHCS, to determine the appropriate amounts to claim as expenditures qualifying for FFP, including the annual submission of the cost reporting form CMS-2552 to the DHCS and any supplemental schedules to compute the net allowable Medi-Cal DP/NF-B cost.

4. Keep, maintain, and have readily retrievable, such records as specified by DHCS to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the Centers for Medicare & Medicaid Services (CMS).

D. Interim Supplemental Payments, Interim Reconciliation, and Final Reconciliation

Reimbursement to an eligible facility, as identified in Paragraph A, will be based on allowable Medi-Cal skilled nursing facility costs. The methodology for computing such costs and the required procedures for claiming FFP is detailed in the Supplemental Reimbursement Methodology, Paragraph B and the paragraphs below.

1. Interim Supplemental Payments

   a. DHCS will make interim Medi-Cal supplemental payments of FFP to eligible facility identified in Paragraph A. The interim payment for each facility is based on the facility's quarterly net allowable Medi-Cal cost. The facility will report to DHCS, on a quarterly basis, the amount of eligible costs per day for the reporting period. The eligible cost per day will be the lesser of the estimated cost per day year-to-date or DHCS' projected cost per day for that facility used for per diem rate-setting purposes (as determined pursuant to Section IV of this Attachment 4.19 D).

   b. The estimated cost per day will be based on the actual direct costs and estimated indirect costs. Each quarter, the actual total allowable skilled nursing facility direct costs incurred by the facility year-to-date will be reported to DHCS. Because actual indirect cost data is not available until the end of the fiscal year, the facility will compute an indirect cost rate from the most recently available prior year cost report.

   c. For purposes of subparagraph b, the indirect cost rate is the ratio of total allowable skilled nursing facility indirect cost (in the CMS 2552-96, the difference between column 27 and column 0 on Worksheet B, Part I, line 34, or in the CMS-2552-10, the difference between column 26 and column 0 on Worksheet B, Part I, line 44), divided by the total allowable skilled nursing facility direct cost (in the CMS 2552-96, Worksheet B, Part I, line 34, column 0, or in the CMS-2552-10, Worksheet B, Part I, line 44, column 0).

   d. After the indirect cost rate is determined in accordance with subparagraph c, it will be applied to the actual direct costs reported year-to-date to estimate the year-to-date skilled nursing facility indirect costs. To calculate the year-to-date estimated cost per day, the facility will divide the estimated costs (actual reported direct costs plus estimated indirect costs) by all patient days (Medicaid and Non-Medicaid) for which services were provided year-to-date.

   e. The eligible cost per day is reduced by Medi-Cal reimbursement rate per day (as determined pursuant to Section IV, paragraph F of this Attachment 4.19 D) for the facility to arrive at net uncompensated cost per day. The net uncompensated cost per day will then be multiplied by the number of Medi-Cal skilled nursing facility days year-to-date, extracted from the CA-MMIS paid claims report. The supplemental payments made for the prior quarters year-to-date are subtracted to arrive at the supplemental payment for the quarter. Quarterly supplemental payments are then made subsequent to the reporting quarter.

2. Reconciliation of Interim Supplemental Payments

   a. As determined pursuant to the methodology in paragraph B and paragraph D.1, the interim supplemental payments will be reconciled based on the facility's as-filed cost report that is submitted to DHCS five months after the close of the facility's spending fiscal year (the spending fiscal year is the actual service period for which the State is providing the supplemental reimbursement to the facility and for which the actual expenditure for FFP is being computed).

   b. The facility will use the routine cost per day from the skilled nursing facility routine cost center. The CMS-2552 computes an allowable cost per day amount on Worksheet D-1, Part III, on line 67 in the CMS-2552-96 and on Worksheet D-1, Part III, line 71 in the CMS-2552-10.

   c. To compute the allowable uncompensated skilled nursing facility cost per day, the facility will subtract the Medi-Cal per diem rate paid from the routine cost per day for the spending period.

   d. To compute the total allowable uncompensated cost, the facility will multiply the uncompensated cost per day by the number of paid Medi-Cal skilled nursing facility days for the spending period, extracted from the CA-MMIS paid claims reports. The allowable uncompensated cost is further reduced by any other revenue received for the Medi-Cal services not previously accounted for in paragraph D. 2 c. The net allowable Medi-Cal cost would represent the facility's eligible expenditures, on which DHCS would claim the FFP for the supplemental payment.

   e. If at the end of the reconciliation of the interim payments it is determined that the eligible facility has been overpaid (i.e., the total computable of the supplemental payment amount(s) exceeds the allowable net Medi-Cal cost), the facility will repay the Medi-Cal program, and DHCS will follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If at the end of the reconciliation of the interim payments, it is determined that the eligible facility has been underpaid, the facility will receive an adjusted supplemental payment amount.

   f. DHCS will complete the interim reconciliation for the claiming period within 1 year after the postmark date of the as-filed cost report.

3. Final Reconciliation

   a. Within four years after the as filed cost report is submitted, all payments will be reconciled to the facility's finalized spending year cost report as audited and settled by DHCS. During the final reconciliation, net allowable Medi-Cal cost will be computed in accordance with step D.2 above, except using cost and total day data from the cost report for the spending fiscal year as finalized by DHCS during its audit and settlement process. Updated CA-MMIS reports and facility specific data will be used in the final reconciliation to determine final Medi-Cal days and payments for the Medi-Cal services furnished in the spending period. Actual net

allowable Medi-Cal cost is compared to the total computable interim expenditures made for the spending period.

b. If at the final reconciliation, it is determined that the eligible facility has been overpaid (i.e., the total computable expenditures that were used to claim the supplemental payment FFP amount(s) exceed the allowable net Medi-Cal cost), the facility will repay the Medi-Cal program the overpayment amount, and DHCS will follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If at the end of the final reconciliation, it is determined that the eligible facility has been underpaid, the facility will receive an adjusted supplemental payment amount.

c. DHCS will complete the final reconciliation for the claiming period within four years after the postmark date of the as-filed cost report.

All cost report information for which Medi-Cal payments are determined and reconciled are subject to CMS review and must be furnished upon request. All reconciliations will be made on a date-of-service basis. Adjustments for prior year payments must be properly accounted for on the CMS 64.

E. Department's Responsibilities

1. DHCS will submit claims for FFP for the expenditures as specified in paragraph B.2 above for services that are allowable expenditures under federal law.

2. DHCS will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for FFP will include only those expenditures that are allowable under federal law.

3. Total computable expenditures certified under this segment of the State Plan will not exceed any applicable federal upper payment limit.

4. DHCS has in place a public process, which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act.

5. DHCS will audit and settle the cost reports filed by the facilities in determining the actual Medi-Cal expenditures eligible for claiming this supplemental payment. DHCS will follow Medicare cost principles and Medicare cost reporting methodologies in determining allowable costs, in accordance with CMS Provider Reimbursement Manual, Parts I and II and 42 CFR Part 413, and other applicable federal directives which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning allowable costs to program beneficiaries.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

LONG TERM CARE (LTC) CLASSES TO BE USED FOR RATE-SETTING PURPOSES

PATIENT ACUITY LEVELS	*ORGANIZATION TYPE*	*No. of Beds*	*Geographical Location*	*Reimbursement Basis*
NF LEVEL B	-Distinct part NF	All	Statewide	*
(EXCEPT SUBACUTE,	-Freestanding NF	1-59	Los Angeles Co.	Median
PEDIATRIC SUBACUTE,		1-59	Bay Area**	Median
and TRANSITIONAL		1-59	All Other Counties	Median
INPATIENT CARE		60+	Los Angeles Co.	Median
		60+	Bay Area**	Median
		60+	All Other Counties	Median
SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	*
NON-VENTILATOR	-Distinct part NF	All	Statewide	*
DEPENDENT	-Freestanding NF	All	Statewide	*
PEDIATRIC SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NON-VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NSITIONAL INPATIENT CARE:				
ABILITATIVE	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
MEDICAL	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NF LEVEL A	-All	1-99	Los Angeles Co.	Median
		1-99	Bay Area**	Median
		1-99	All Other Counties	Median
		100+	Statewide	***
ICF/DD	-All	1-59	Statewide	65th percentile
		60+	Statewide	65th percentile
ICF/DD-Hs and Ns	-All	4-6	Statewide	65th percentile
		7-15	Statewide	65th percentile
RURAL SWING-BED NF LEVEL B SERVICES	-Rural acute hospitals	All	Statewide	Median

* DP/NF level Bs and Subacute providers are reimbursed at either the lesser of costs as projected by the Department or the prospective median rate of the LTC class.

** Bay area is defined as San Francisco, San Mateo, Marin, Napa, Alameda, Santa Clara, Contra Costa, and Sonoma counties.

*** Current rate increased by the same percentage rate as received by other NF level As.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

IX. STATE VETERANS HOMES SUPPLEMENTAL REIMBURSEMENT

This segment of the State Plan describes supplemental reimbursement for a State Veterans Home that is operated by California Department of Veterans Affairs (CDVA), which meets specified requirements, and provides skilled nursing services to Medi-Cal beneficiaries.

A. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity continuously has all of the following characteristics during Department of Health Care Services' (DHCS') rate year beginning August 1, 2006, and subsequent rate years:

1. Provides skilled nursing services to Medi-Cal beneficiaries.
2. Is a State home for Veterans, as defined in United States Code Title 38 (Veterans Benefits), Part 1, Chapter 1, Section 101.
3. Is operated by the State of California.

CDVA must provide reliable data, cost reports, and other information for the computation of the facility's allowable cost incurred for the provision of covered routine and ancillary skilled nursing services to Medi-Cal beneficiaries.

B. Supplemental Reimbursement Methodology

1. The expenditures reported to DHCS by CDVA, represents the allowable cost incurred for the provision of covered routine and ancillary skilled nursing services to Medi-Cal beneficiaries. Such costs are based on the cost reporting form CMS-2540 for freestanding nursing facilities and CMS-2552 for hospital-based nursing facilities. CDVA will use the CMS-2540 or CMS-2552 to determine total allowable cost and apportion that cost to Medi-Cal services in accordance with the established CMS-2540 and CMS-2552 apportionment methodology. See Paragraph F for detailed cost determination protocol.

2. For each facility, the net Medi-Cal cost which may be certified to DHCS for purposes of claiming federal financial participation (FFP) pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations (CFR) is the total allowable Medi-Cal cost as determined pursuant to Paragraph B.1 less all other payments received by CDVA for covered Medi-Cal routine and ancillary skilled nursing services, including any base Medi-Cal per diem payments and any allowable beneficiary and third party payments; except as otherwise noted in this segment of the State Plan or specifically exempted by applicable federal law or regulation. Total computable supplemental reimbursement under this Section IX that is the basis for the claim for FFP will not be deducted from the allowable Medi-Cal cost for purposes of determining the net Medi-Cal cost which may be certified.

3. Pursuant to Section 202 of the Veterans Health Program Improvement Act of 2004, per diem payments made by the federal Department of Veterans Affairs to the State as payments for nursing home care provided to Medi-Cal eligible veterans in a facility recognized as a state home for nursing home care will not be used to offset or reduce the Medicaid reimbursement amount for the provision of nursing home services to Medi-Cal beneficiaries.

4. The total computable supplemental reimbursement that is the basis for the claim for FFP under this program must not be greater than the difference between total allowable cost for Medi-Cal covered skilled nursing services and the total reimbursement received by the facility for such services, including the amount paid under the reimbursement methodology specified in supplement 4 to this Attachment 4.19-D, Section VIII.A (at page 17).

5. The total Medi-Cal reimbursement received by a facility eligible under this program, when combined with the amount received from other sources of payment for covered Medi-Cal skilled nursing facility services (except as exempted in paragraph 3 above), will in no instance exceed 100 percent of costs for covered Medi-Cal skilled nursing services at each facility.

C. Facility Reporting Requirements

CDVA will do all of the following:

1. Certify that the claimed expenditures for skilled nursing services are eligible for FFP pursuant to Section 433.51 of Title 42 of the CFR.

2. Provide evidence supporting the expenditures reported as specified by DHCS.

3. Submit data, as specified by DHCS, to determine the appropriate amounts to claim as expenditures qualifying for FFP, including the annual submission of the cost reporting form CMS-2540 or CMS-2552 to the DHCS and any supplemental schedules to compute the net allowable Medi-Cal skilled nursing services cost.

4. Keep, maintain, and have readily retrievable, such records as specified by DHCS to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the Centers for Medicare & Medicaid Services (CMS).

D. Interim Supplemental Payments, Initial and Final Reconciliations

Reimbursement to a veterans home that is operated by the state, as identified in Paragraph A, will be based on allowable Medi-Cal skilled nursing facility (SNF) costs. The methodology for computing such costs and the required procedures for claiming FFP is detailed in the Supplemental Reimbursement Methodology, Paragraph B and in the Cost Determination Protocol, Paragraph F.

1. Interim Supplemental Payments

DHCS is authorized to make interim Medi-Cal supplemental payments to eligible veterans homes identified in Paragraph A. The interim payment for each facility is based on the facility's estimated annual net allowable Medi-Cal cost, computed in accordance with the Cost Determination Protocol in Paragraph F. However, for interim payment purposes, the cost, day and charge, and payment data used will be for the most recent fiscal period for which an as-filed cost report is available. DHCS will divide the estimated annual net allowable Medi-Cal cost by four to arrive at the eligible expenditure amount for each quarter. The quarterly expenditure amount is the basis for the interim Medi-Cal supplemental payments, to be made each quarter during the fiscal year.

2. Initial Reconciliation

a. As determined pursuant to the methodology in paragraph B, the interim supplemental payments will be reconciled based on the facility's as-filed cost report that is submitted to DHCS five months after the close of the facility's spending fiscal year (the spending fiscal year is the actual service period for which the State is providing the supplemental reimbursement to the facility and for which the actual

expenditure for FFP is being computed). During this initial reconciliation, net allowable Medi-Cal cost will be computed using cost, day and charge, and payment data for the spending fiscal year covered by the as-filed cost report. Updated California Medicaid Management Information System (CA-MMIS) reports and facility specific data will be used to determine payments for the Medi-Cal services in the initial reconciliation for the spending fiscal year covered by the as-filed cost report. Actual net allowable Medi-Cal cost will be reduced by all payments received for Medi-Cal beneficiaries for the spending period, except as provided for in paragraph B.3 above.

b. If at the end of the initial reconciliation it is determined that the eligible facility has been overpaid, the facility will repay the Medi-Cal program, and DHCS will follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If at the end of the initial reconciliation, it is determined that the eligible facility has been underpaid, the facility will receive an adjusted payment amount.

c. Reconciliation will be made on a date-of-service basis. Adjustments for prior year payments must be properly accounted for on the CMS 64.P.

d. All cost report information for which Medi-Cal payments are determined and reconciled are subject to CMS review and must be furnished upon request.

3. Final Reconciliation

a. Within three years after the as filed cost report is submitted, all payments will be reconciled to the facility's finalized spending year cost report as audited and settled by DHCS. During the final reconciliation, net allowable Medi-Cal cost will be computed using cost, day and charge, and payment data for the spending fiscal year as finalized by DHCS during its audit and settlement process. Updated California Medicaid Management Information System (CA-MMIS) reports and facility specific data will be used to determine final payments for the Medi-Cal services in the final reconciliation. Actual net allowable Medi-Cal cost is compared to the interim payments, including any initial reconciliation payments, made for the spending period.

b. If at the final reconciliation, it is determined that the eligible facility has been overpaid, the facility will repay the Medi-Cal program, and DHCS will follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If at the end of the final reconciliation, it is determined that the eligible facility has been underpaid, the facility will receive an adjusted payment amount

c. Reconciliation will be made on a date-of-service basis. Adjustments for prior year payments must be properly accounted for on the CMS 64.P.

d. DHCS will complete the final reconciliation for the claiming period within four years after the postmark date of the as-filed cost report.

E. Department's Responsibilities

1. DHCS will submit claims for FFP for the expenditures as specified in paragraph B.2 above for services that are allowable expenditures under federal law.

2. DHCS will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for FFP will include only those expenditures that are allowable under federal law.

3. Total Medi-Cal reimbursement under this segment of the State Plan will not exceed any applicable federal upper payment limit.

4. DHCS has in place a public process, which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act.

5. DHCS will audit and settle the cost reports filed by the facilities in determining the actual Medi-Cal expenditures eligible for this supplemental payment. DHCS will follow Medicare cost principles and Medicare cost reporting methodologies in determining allowable costs, in accordance with CMS Provider Reimbursement Manual, Parts I and II and 42 CFR 413, and other applicable federal directives which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning allowable costs to program beneficiaries.

F. Cost Determination Protocol

Each facility will follow the following steps in the determination of each facility's net allowable cost incurred for the provision of covered skilled nursing services to Medi-Cal beneficiaries:

1. Freestanding Skilled Nursing Facilities (CMS-2540) -

   a. For the SNF routine cost center, the CMS-2540 computes an allowable cost per day amount on Worksheet D-1, Part I, line 16. To compute the allowable Medi-Cal routine cost, the number of covered Medi-Cal SNF days for the cost reporting period, extracted from the CA-MMIS paid claims report, is multiplied by the allowable cost per day amount from Worksheet D-1.

   b. For each ancillary cost center, the CMS-2540 computes a cost-to-charge ratio on Worksheet C, column 3, lines 21 to 33. To compute the allowable Medi-Cal ancillary cost for each cost center, the actual Medi-Cal covered ancillary charges for the cost reporting period (either extracted from the CA-MMIS paid claims report or as reported by CDVA based on financial and/or patient accounting records that, for the purpose of auditing, are consistent with Medicare Cost Accounting principles and mapped to the individual cost center) are multiplied by that cost center's cost-to-charge ratio from Worksheet C. The Medi-Cal covered ancillary charges include only the covered services that are reimbursable as skilled nursing facility services under Attachment 4.19-D of the California State Plan and should not include any services that are reimbursed under Attachment 4.19-B as non-institutional services.

   c. The total allowable Medi-Cal cost for the facility is the sum of the total allowable Medi-Cal SNF routine cost from above, in paragraph a. and the total allowable Medi-Cal ancillary cost from above, in paragraph b.

   d. The total allowable Medi-Cal cost is then offset by all payments received for the covered Medi-Cal routine and ancillary skilled nursing services; except otherwise noted herein or specifically exempted by applicable federal law or regulation. The payment offsets include any Medi-Cal base payments from the State, made under Attachment 4.19-D of the State Plan (other than payments made under this Section) and also any payments from the beneficiary or third parties for the covered Medi-Cal skilled nursing services. The net allowable Medi-Cal cost would represent the facility's eligible expenditures for supplemental payment.

2. Hospital-Based Skilled Nursing Facilities (CMS-2552):

   a. For the SNF routine cost center, the CMS-2552 computes an allowable cost per day amount on Worksheet D-1, Part III, on line 67. To compute the allowable Medi-Cal SNF routine cost, the number of covered Medi-Cal SNF days for the cost reporting period, extracted from the CA-MMIS paid claims report, is multiplied by the allowable cost per day amount from Worksheet D-1.

   b. For each ancillary cost center, the CMS-2552 computes a cost-to-charge ratio on Worksheet D-4, column 1, lines 37 to 59. To compute the allowable Medi-Cal ancillary cost for each cost center, the actual Medi-Cal covered ancillary charges for the cost reporting period (either extracted from the CA-MMIS paid claims report or as reported by CDVA based on financial and/or patient accounting records that, for the purpose of auditing, are consistent with Medicare Cost Accounting principles and mapped to the individual cost center) are multiplied by that cost center's cost-to-charge ratio from Worksheet D-4. The Medi-Cal covered ancillary charges include only the covered services that are reimbursable as skilled nursing facility services under Attachment 4.19-D of the California State Plan and should not include any services that are reimbursed under Attachment 4.19-B as non-institutional services.

   c. The total allowable Medi-Cal cost for the facility is the sum of the total allowable Medi-Cal routine cost from above, in paragraph a. and the total allowable Medi-Cal ancillary cost from above, in paragraph b.

   d. The total allowable Medi-Cal cost is then offset by all payments received for the covered Medi-Cal routine and ancillary skilled nursing services; except otherwise noted herein or specifically exempted by applicable federal law or regulation. The payment offsets include any Medi-Cal base payments from the State, made under Attachment 4.19-D of the State Plan (other than payments made under this Section) and also any payments from the beneficiary or third parties for the covered Medi-Cal skilled nursing services. The net allowable Medi-Cal cost would represent the facility's eligible expenditures for supplemental payment.

IX. ICF/DD DAY TREATMENT SUPPLEMENTAL REIMBURSEMENT PROGRAM

A. Overview

This program provides supplemental reimbursement for the costs of day treatment, including non-medical transportation costs to and from such treatment, provided to Medi-Cal beneficiaries who are residents of Intermediate Care Facilities/Developmentally Disabled (ICF/DDs), excluding those that are operated by the State of California as Developmental Centers. ICF/DDs include ICF/DD-Habilitative facilities and ICF/DD-Nursing facilities.

The California Department of Developmental Services (CDDS) will provide supplemental reimbursement to ICF/DDs for day treatment, including non-medical transportation to and from such treatment. ICF/DD residents receive these services pursuant to the Lanterman Developmental Disabilities Services Act.

B. Definitions

For purposes of this Section IX, the following definitions shall apply.

1. "Day Treatment" means the authorized participation of Medi-Cal beneficiaries who are residents of ICF/DDs in a program that provides social, habilitative, adaptive, recreational, developmental, or learning services to individuals on an hourly or daily basis, but less than on a 24-hour basis.

2. "Authorized participation" in the day treatment program means that the program, and non-medical transportation to the program, is included in the resident's individualized needs assessment and individual program plan developed by the resident's person-centered planning team together with the resident or his or her representative pursuant to California Welfare and Institutions Code sections 4646 and 4646.5. The person-centered planning team will periodically review such participation for continuing appropriateness.

3. "Non-medical transportation" means the transport of Medi-Cal beneficiaries who are residents of ICF/DDs between their authorized participation in the day treatment program and the ICF/DDs.

4. "Person-centered" refers to the individual program plan and provision of services and support by the Regional Center system that focuses on the individual and the family of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, where appropriate, as well as promoting community integration, independent, productive, and normal lives, and stable and healthy environments.

5. "Department of Health Care Services" (DHCS) refers to the department formerly known as the Department of Health Services (DHS), and referred to as

such in other chapters of this state plan, whose name was officially changed on July 1, 2007.

C. Supplemental Reimbursement Methodology

Calculation and payment of the supplemental reimbursement for this program will be as follows:

1. An ICF/DD, or the Regional Center acting on its behalf, shall bill CDDS for the ICF/DD's costs of an ICF/DD resident's authorized participation in a day treatment program, including non-medical transportation to such treatment program. The bill shall not exceed:

(1) the allowable direct costs of providing the day treatment and non-medical transportation, equal to the amount that would be paid by a Regional Center to subcontracting providers for such services, plus

(2) a 1.5% add-on to the amount in (1) above to account for the regional center's administrative costs in making disbursements on behalf of the ICF/DD provider for these services, plus

(3) a 1.5% add-on to the resulting amount in (1 and 2) above to account for the ICF/DD's administrative costs in the provision of these services, plus

(4) an amount equal to the California ICF/DD quality assurance fee percentage in effect for the applicable period, times the sum of items (1) through (3) above. This provides reimbursement for the Medicaid service portion of the quality assurance fee paid relative to the reimbursements received for the provision of the day treatment and non-medical transportation services and related administrative fees. This amount will be reimbursed on a per-claim basis in conjunction with the reimbursement for items (1) through (3).

Items (1) and (2) above represent the amount payable by an ICF/DD to a Regional Center when the ICF/DD contracts in accordance with State law with a Regional Center to provide the authorized day treatment program services, including non-medical transportation to such treatment programs, to its residents.

2. The costs reimbursed through this supplemental payment shall not be included in the calculation of the routine per-diem rate provided to ICF/DDs.

3. On a monthly basis, CDDS shall reimburse an ICF/DD for the cost of the day treatment and non-medical transportation provided to its residents, as defined in paragraph C.1 above.

4. On monthly basis, CDDS will submit documentation to DHCS reflecting the amounts paid to the ICF/DDs for the costs incurred in paying for day treatment and non-medical transportation to residents of ICF/DDs.

D. DHCS' Responsibilities

DHCS' responsibilities to ensure the proper administration of this supplemental reimbursement program are as follows:

1. DHCS will submit claims for federal financial participation based on expenditures reported by CDDS pursuant to paragraph C for payments to the ICF/DDs for the costs of providing day treatment and non-medical transportation, as defined in paragraph C.1 above.

2. DHCS will submit any necessary documentation to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law and do not exceed the costs of providing the service components.

3. DHCS will ensure that it does not include the costs reimbursed through the supplemental payment for day treatment and transportation in the calculation of the routine per-diem rate payable to ICF/DDs.

E. CDDS' Responsibilities

CDDS' responsibilities to ensure the proper administration of this supplemental reimbursement program are as follows:

1. CDDS is responsible for making the supplemental payments to the ICF/DDs and for ensuring that its payments to the ICF/DDs comply with the requirements of paragraph C.

State/Territory: California

Payment Adjustment for Provider-Preventable Conditions

Medi-Cal meets the requirements of 42 CFR Part 447, Subpart A, and Social Security Act sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A.

_____ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-D.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Medi-Cal does not reimburse providers for Other Provider-Preventable Condition (OPPC), as identified in Title 42 CFR Part 447.26(b).

Providers shall report any OPPCs that did not exist prior to initiation of treatment for that patient by the provider(s) that are associated with the claim for treatment furnished to Medi-Cal patients for which Medi-Cal payment would otherwise be available. The reporting will be directed to the State. In addition to providers identifying PPCs using the Medi-Cal PPC reporting form, the State will identify and evaluate for payment adjustment any PPCs that it discovers or is made of aware of through other means, including reporting of a PPC by a beneficiary, other providers, or entity communicated in any manner; any review of Medi-Cal claims performed by the State, including audits and Treatment Authorization Requests (TARs); and reviewing charts. The State will accumulate these occurrences, evaluate whether a payment was made, and examine the details regarding each occurrence. The State understands the importance of implementing the provisions of payment adjustments when they occur, regardless of the provider's intent to bill. The State will use the "Federal Voluntary Self-Disclosure Protocol" regarding the evaluation and examination of the OPPCs reported in the inpatient and outpatient settings.

Reduction in payment shall be limited to identified OPPCs that would otherwise result in an increase in payment and to the extent that the State can reasonably isolate for nonpayment, that portion of the payment directly related to the OPPC. Medi-Cal will not reduce payment for an OPPC when the OPPC existed prior to initiation of treatment for that patient by that provider. If the State has not yet paid the claim to treat the OPPC, the State will deny payment to the same provider for the days and services pertaining to treatment of an OPPC that was not present upon admission in excess of the expected payment for the days and services pertaining to treatment of the condition for which the patient was admitted. If the State previously paid for the OPPC, the State will withhold future payment to the provider in an amount equivalent to any increase in payment to treat the OPPC that the provider did not identify as existing prior to initiating treatment for that patient.

The State will adjust Medicare crossover payments to remove additional payment for OPPCs. If the Medicare crossover claim has an OPPC diagnosis that was not present prior to the initiation of treatment for the patient by that provider, the State will exclude the OPPC from the payment calculation when it can reasonably isolate increased payments directly attributable to the OPPC.

The State may examine reported and discovered OPPCs.