DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services (CMCS)

Toby Douglas
Director of Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

DEC 19 2012

RE: California State Plan Amendment TN: 12-021

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-021. This amendment provides for supplemental payments up to actual Medicaid cost for governmental distinct part skilled nursing facilities, effective August 1, 2012.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 12-021 is approved effective August 1, 2012. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Mark Wong or Annalisa Fichera at (415) 744-3561 or (415) 744-3577.

Sincerely,

Cindy Mann
Director, CMCS

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12-021

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: August 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 433.51 42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 12-13 ~~$1,000,000~~ 537,780
b. FFY 13-14 ~~$3,000,000~~ 3,239,127

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D
Pages ~~18-22~~ 18, 19, 20, 21, 21a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D
Pages ~~18-22~~ 18, 19, 20, 21

10. SUBJECT OF AMENDMENT:
Public Hospital Distinct Part Nursing Facility Supplemental Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Toby Douglas

14. TITLE: Director

15. DATE SUBMITTED: SEP 25 2012

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: DEC 19 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG - 1 2012

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:
Per & pen changes to blocks 6,7,8,9 by RO with state concurrence on 12/13/12.

FORM HCFA-179 (07-92)

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.

ENCLOSURE **FOR STAKEHOLDERS ONLY

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

12-021*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	Insert Page(s)
Attachment 4.19-D, pages 18-21	Attachment 4.19-D, pages 18-21, 21a