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

OCT 2 7 2011

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

RE: California State Plan Amendment TN: 10-015

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-015. This amendment provides for various changes to the reimbursement rate setting methodology for freestanding skilled nursing facilities level-B and freestanding subacute skilled nursing facilities level-B, effective August 1, 2010, including a lift of a rate freeze for the 2010-2011 rate year, 3.93% increase for the 2010-2011 rate year and a 2.4% increase for the 2011-2012 rate year.

We conducted our review of your submittal with particular attention to the statutory requirements at sections 1902(a)(13), and 1902(a)(30), of the Social Security Act. Because I find that this amendment complies with all applicable requirements, Medicaid State plan amendment 10-015 is approved effective August 1, 2010. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

Cindy Mann
Director
Center for Medicaid and State Operations

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: 10-015

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, 2010

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 447 Subpart B Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 ~~$12,625,950~~ $16,306,978
b. FFY 2011 ~~$75,070,300~~ $85,094,504

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 4 to Attachment 4.19-D, pages 1, 1.1, 6, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 4 to Attachment 4.19-D, pages 1, 6,8,9,10,11, 14,15,16,17

10. SUBJECT OF AMENDMENT:
Freestanding Skilled Nursing Facilities Reimbursement Rates

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:
Chief Deputy Director

15. DATE SUBMITTED:

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: OCT 27 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: ~~OCT 27 2011~~ AUG - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: CINDY MANN

22. TITLE: DIRECTOR, CMCS

23. REMARKS:

Pen-and-ink change made to Boxes 6, 7, and 8 by Regional Office with State concurrence.

FORM HCFA-179 (07-92)

METHODS AND STANDARDS FOR ESTABLISHING FACILITY-SPECIFIC REIMBURSEMENT RATES FOR FREESTANDING SKILLED NURSING FACILITIES LEVEL-B AND SUBACUTE CARE UNITS OF FREESTANDING SKILLED NURSING FACILITIES

I. Introduction

A. This document, labeled Supplement 4 to Attachment 4.19-D, describes the overall reimbursement rate methodology for skilled nursing facility services provided to Medi-Cal recipients by: (1) freestanding skilled nursing facilities level-B (FS/NF-B), both publicly and privately operated, and (2) subacute care units of FS/NF-Bs as defined in California Code of Regulations, title 22, section 51124.5.

B. This Supplement is submitted by the single State Medicaid (Medi-Cal) Agency, the State of California Department of Health Services (hereinafter "Department"). This Supplement is necessary to describe changes to the FS/NF-B reimbursement rate methodology adopted by the 2004 State Legislature in Assembly Bill (AB) 1629, signed into law on September 29, 2004, as Chapter 875 of the Statutes of 2004.

C. AB 1629 establishes the Medi-Cal Long-Term Care Reimbursement Act, which mandates a facility-specific rate-setting methodology effective on August 1, 2005; and which will cease to be operative on and after July 31, 2008. This statute requires the Department to develop and implement a Medi-Cal cost-based facility-specific reimbursement rate methodology for Medi-Cal participating FS/NF-Bs, including FS/NF-Bs with subacute care beds. AB 203, signed into law on August 24, 2007, as Chapter 188 of the Statutes of 2007, extends the operative date to July 31, 2009. AB 1183, signed into law on September 30, 2008, as Chapter 758 of the Statutes of 2008, extends the operative date to July 31, 2011. SB 853, signed into law on October 19, 2010, as Chapter 717 of the statutes of 2010, extends the operative date to July 31, 2012.

D. The cost-based reimbursement rate methodology is intended to reflect the costs and staffing levels associated with the quality of care for residents in FS/NF-Bs. This methodology will be effective August 1, 2005, and will be implemented the first day of the month following federal approval. A retroactive increase in reimbursement rates to August 1, 2005, to FS/NF-Bs will be provided in the event that federal approval occurs after the effective date of the methodology.

E. The reimbursement rates established will be based on methods and standards described in Section V of this Supplement.

F. Provisions of this legislation require that the facility-specific reimbursement rates for rate years 2005/06 and 2006/07 will not be less than the rates developed based upon the methodology in effect as of July 31, 2005, as described in Attachment 4.19-D, Pages 1 through 22 of the State Plan, plus projected proportional costs for new state or federal mandates for the applicable rate years.

B. The prospective per diem payment for each FS/NF-B is computed on a per resident day basis. For the rate year beginning August 1, 2010, and for subsequent years, professional liability insurance costs are included as a major cost category. The per diem payment is comprised of the following major cost categories:

1. labor costs
2. indirect care non-labor costs
3. administrative costs
4. professional liability insurance costs
5. capital costs
6. direct pass-through costs.

Payment for FS/NF-Bs will be based on facility-specific cost-based reimbursement rates consisting of the major cost categories, and determined as described in the following Section V.C. of this Supplement.

C. Cost Categories. The facility-specific cost-based per diem payment for FS/NF-Bs is based on the sum of the projected costs of the major cost categories, each subject to ceilings described in this Section. Costs within a specific cost category may not be shifted to any other cost category. In addition, per diem payments will be subject to overall limitations described in Section VI of this Supplement.

1. The labor cost category is comprised of a direct resident care labor cost component, an indirect care labor cost component, and a labor-driven operating allocation cost component. For the rate year beginning August 1, 2010, and for subsequent years, the labor-driven operating allocation cost component is eliminated. These components are comprised of more specific elements described below:

   a. Direct resident care labor costs include salaries, wages, and benefits related to routine nursing services personnel, defined as nursing, social services, and activities personnel. Direct resident care labor costs include labor expenditures associated with a FS/NF-B's permanent direct care employees, as well as expenditures associated with temporary agency staffing. These costs are limited to the 90th percentile of each FS/NF-B's respective peer-group, as described in Section VII of this Supplement.

      i. For the rate year beginning August 1, 2005, and for subsequent rate years, the direct resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal direct

Resident care labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

iii. An inflation index, based on the Department's labor study, developed from the most recently available industry-specific historical wage data as reported to OSHPD by providers will be applied to the FS/NF-B's allowable indirect resident care labor per diem costs. Each facility's indirect resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

c. Labor-driven operating allocation includes an amount equal to eight percent of direct and indirect resident care labor costs, less expenditures for agency staffing, such as nurse registry and temporary staffing agency costs. The labor-driven operating allocation may be used to cover allowable Medi-Cal expenditures incurred by a FS/NF-B to care for Medi-Cal residents. In no instance will the operating allocation exceed five percent of the facility's total Medi-Cal reimbursement rate. For the rate year beginning August 1, 2010, and for subsequent rate years, the labor driven operating allocation is eliminated as a cost component for the labor cost category.

2. Indirect care non-labor costs include the non-labor costs related to services supporting the delivery of resident care, including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education and plant operations and maintenance costs. These costs are limited to the 75th percentile of each facility's respective peer-group, as described in Section VII of this Supplement.

a. For the rate year beginning August 1, 2005, and for subsequent rate years, the indirect care non-labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal indirect care non-labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF B's allowable indirect care non-labor per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate year.

3. Administrative costs include allowable administrative and general expenses of operating the facility, including a FS/NF-B's allocated expenditures related to allowable home office costs. The administrative cost category will include allowable property insurance costs, and exclude expenditures associated with caregiver training, liability insurance, facility license fees, and medical records. For the rate year beginning August 1, 2010, and subsequent rate years, legal and consultant fees are excluded as stated below.

   a. For the rate year beginning August 1, 2005, and for subsequent rate years, the administrative per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer-grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 50th percentile of the allowable Medi-Cal administrative cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

   b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF-B's allowable administrative per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate year.

   c. For the rate year beginning August 1, 2010, and for subsequent rate years, the administrative cost category will exclude any legal or consultant fees in connection with a fair hearing or other litigation against or involving any government agency or department until all issues related to the fair hearing or litigation issues are ultimately decided or resolved in favor of the FS/NF-B's.

4. For the rate year beginning August 1, 2010, and for subsequent rate years, the professional liability per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer-grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of the allowable Medi-Cal cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount. FS/NF-Bs must report the insurance deductibles in a format and by the deadline determined by the Department, or the deductibles will be reimbursed at the 50th percentile in the administrative cost category.

5. Capital costs. For the rate year beginning August 1, 2005, and for subsequent rate years, a Fair Rental Value System (FRVS) will be used to reimburse FS/NF-B's property (capital) costs. Under the FRVS, the Department reimburses a facility based on the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, rent or lease payments. The FRVS establishes a facility's value based on the age of the facility. For rate years subsequent to 2005/06, additions and renovations (subject to a minimum per-bed limit) will be recognized by lowering the age of the facility. The facility's value will not be affected by sale or change of ownership. Capital costs, limited as specified below in Section V.C.4.e. of this Supplement, are derived from the FRVS parameters as follows:

   a. The initial age of each facility is determined as of the mid-point of the 2005/06 rate year, using each facility's original license date, year of construction, initial loan documentation, or similar documentation. For the 2005/06 rate year, all FS/NF-Bs with an original license date of February 1, 1976, or prior, will have five years subtracted from their facility age to compensate for any improvements, renovations or modifications that have occurred in the past. The age of each facility will be adjusted every rate year to make the facility one year older, up to a maximum age of 34 years.

   b. For the 2006/07, 2007/08, 2008/09, 2009/10, 2010/11 and for subsequent rate years costs incurred for major capital improvements, modifications or renovations equal to or greater than $500 per bed on a total licensed-bed basis will be converted into an equivalent number of new beds, effectively lowering the age of the facility on a proportional basis. If a facility adds or replaces beds, these new beds will be averaged in with the age of the original beds, and the weighted average age of all beds will represent the facility's age. If a facility performs a major renovation or replacement project (defined as a project with capitalized cost equal to or greater than $500 per bed, on a total bed basis), the cost of the renovation project will be converted to an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility.

   c. The FRVS per diem calculation, subject to the limitations identified in Section V.C.4.e. of this Supplement, is calculated as follows:

i. An estimated building value will be determined based on a standard facility size of 400 square feet per bed, each facility's licensed beds, and the R.S. Means Building Construction Cost Data, adjusted by the location index for each locale in the State of California. The estimated building value will be trended forward annually to the mid-point of the rate year using the percentage change in the R.S. Means Construction Cost index.

ii. An estimate of equipment value will be added to the estimated building value in the amount of $4,000 per bed.

iii. The greater of the estimated building and equipment value or the fully depreciated building and equipment value will be determined for each facility (hereinafter, the "current facility value"). The fully depreciated building and equipment value is based on a 1.8 percent annual depreciation rate for a full 34 years.

iv. An estimate of land value will be added to the current facility value based on ten percent of the estimated building value as calculated in Section V.4.C.c.i. of this Supplement.

v. A facility's fair rental value is calculated by multiplying the facility's current value plus the estimated land value, times a rental factor. The rental factor will be based on the average 20-year U.S. Treasury Bond yield for the calendar year preceding the rate year plus a two percent risk premium, subject to a floor of seven percent and a ceiling of ten percent.

vi. The facility's fair rental value is divided by the greater of actual resident days for the cost reporting period, or occupancy-adjusted resident days, based on the statewide average occupancy rate. Days from partial year cost reports will be annualized in the FRVS per diem payment calculation.

d. Continued explanation and examples of the FRVS per diem calculations follow:

e. The capital costs based on FRVS will be limited as follows:

i. For the 2005/06 rate year, the capital cost category for all FS/NF-Bs in the aggregate will not exceed the Department's estimate of FS/NF-B's capital reimbursement for the 2004/05 rate year, based on the methodology in effect as of July 31, 2005.

ii. For the 2006/07, 2007/08, 2008/09, 2009/10, 2010/11 and for subsequent rate years, the maximum annual increase for the capital cost category for all FS/NF-Bs in the aggregate will not exceed eight percent of the prior rate year's FRVS aggregate payment.

iii. If the total capital cost category for all FS/NF-Bs in the aggregate for the 2005/06 rate year exceeds the value of the capital cost category for all FS/NF-Bs in the aggregate for the 2004/05 rate year, the Department will reduce the capital cost category for each and every FS/NF-B in equal proportion.

iv. If the capital cost category for all FS/NF-Bs in the aggregate for the 2006/07, 2007/08, 2008/09, 2009/10, 2010/11 and for subsequent rate years exceeds eight percent of the prior rate year's cost category, the Department will reduce the capital FRVS cost category for each and every FS/NF-B in equal proportion.

6. Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, the Medi-Cal portion of the skilled nursing facility quality assurance fee, and new state and federal mandates for the applicable rate year. For the rate year beginning August 1, 2010, and for subsequent rate years, liability insurance costs are excluded from the direct-pass-through cost category.

a. For the rate year beginning August 1, 2005, and for subsequent rate years, the Medi-Cal proportional share of the pass-through per diem costs will be calculated as the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report and/or supplemental schedule(s), as adjusted for audit findings.

b. Caregiver training costs are defined as a formal program of education that is organized to train students to enter a caregiver

occupational specialty. Until the Medi-Cal cost report is revised to specifically identify these costs, FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

c. The Medicare reimbursement principles consistent with Title 42, Code of Federal Regulations, Part 413 will be used to determine reasonable allowable pass through costs for professional liability insurance. FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting. For the rate year beginning August 1, 2010, and for subsequent rate years, liability insurance costs are excluded from the direct pass-through cost category.

d. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to update caregiver training costs and liability insurance costs from the mid-point of the cost report period or supplemental report period to the mid-point of the rate year. For the rate year beginning August 1, 2010, and for subsequent rate years, liability insurance costs are excluded from the direct pass-through cost category.

e. Property tax pass-through costs will be updated at a rate of two percent annually from the mid-point of the cost report period to the mid-point of the rate year.

f. Facility-license fee pass-through costs and the Medi-Cal portion of the skilled nursing facility quality assurance fee will be applied on a prospective basis for each rate year, and will not require an inflation adjustment.

D. For the 2005/06 and 2006/07 rate years, the facility-specific Medi-Cal reimbursement rate calculated under the methodology set forth in Section V of this Supplement will not be less than the Medi-Cal reimbursement rate that the FS/NF-B would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005/06 and 2006/07, respectively.

E. Pursuant to AB 1629, the details, definitions and formulas may be set forth in regulations and provider bulletins or similar instructions.

F. The Department will establish reimbursement rates pursuant to AB 1629 on the basis of facility cost data reported in the Integrated Long-Term Care Disclosure and Medi-Cal Cost Report required by Health and Safety Code section 128730 for the most recent reporting period available and cost data reported in other facility financial disclosure reports, supplemental reports, or surveys required by the Department.

G. The percentiles in labor costs, indirect care non-labor costs, and administrative costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis. For the rate year beginning August 1, 2010, and for subsequent rate years, professional liability costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis

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

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

A. For the 2005/06 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed eight percent of the weighted average reimbursement rate for the 2004/05 rate year, as adjusted for the change in the cost to the FS/NF-B to comply with the skilled nursing facility quality assurance fee for the 2005/06 rate year, plus the total projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

B. For the 2006/07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed five percent of the weighted average Medi-Cal rate for the 2005/06 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

C. For the 2007/08 and 2008/09 rate years, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medi-Cal rate for the 2006/07 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

D. For the 2009/10 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not be increased over the weighted average Medi-Cal rate for the 2008-09 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Payment reductions will be monitored in accordance with the monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services.

E. For the 2010/11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3.93 percent of the weighted average rate from the 2009/10 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

F. For the 2011/12 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 2.4 percent of the weighted average rate from the 2010/11 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

G. To the extent that the prospective facility-specific reimbursement rates are projected to exceed the adjusted limits calculated pursuant to VI.A, VI.B, VI.C, and VI. D, VI. E and VI.F. of this Supplement, the Department will adjust the increase to each FS/NF-B's projected reimbursement rate for the applicable rate year by an equal percentage.

VII. Peer-Grouping

The percentile caps for FS/NF-B facility labor, indirect care non-labor, administrative, and for the rate year beginning August 1, 2010 and subsequent rate years professional liability costs will be computed on a geographic peer-grouped basis. The median per diem direct resident care labor cost for each individual county will be subjected to a statistical clustering algorithm, based on commercially available statistical software. The statistical analysis of county costs will result in a defined and finite number of peer groups. A list of counties and their respective peer groups, along with a more detailed explanation of the peer-grouping methodology is available on-line at: http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629Policy.aspx, or by contacting the Department at:

California Department of Health Care Services
Medi-Cal Benefits, Waiver Analysis, and Rates Division/Long-Care System Development Unit
MS 4612
P.O. Box 997417
Sacramento, CA 95899-7417
Phone: (916) 552-9600

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

A. State-owned and operated skilled nursing facilities will receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate.

B. B. New FS/NF-Bs with no cost history in a newly constructed facility, in a location not previously licensed as a FS/NF-B, or an existing facility newly certified to participate in the Medi-Cal program will receive an interim reimbursement rate based on the peer-grouped weighted average Medi-Cal reimbursement rate. Once the FS/NF-B has submitted six months of cost and/or supplemental data, its facility specific rate will be calculated according to the methodology set forth in this supplement. The difference between the FS/NF-B's interim per diem payment rate and the facility-specific per diem payment rate calculated based on Section V of this Supplement will be determined upon audit or review of the cost report and/or supplemental report. The Department will adjust the difference in reimbursement rate on a prospective basis, consistent with the methodology described in Section IV.C.2 of this Supplement.

C. Changes of ownership or changes of the licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. In instances where the previous provider participated in the Medi-Cal program, the Department will reimburse the new owner or operator the per diem payment rate of the previous provider until the new owner or operator has submitted six or more months of cost and/or supplemental data. If, upon audit or review, the per diem payment rate calculated for the new owner or operator is less than the per diem payment rate of the previous owner or operator, the Department will prospectively adjust the new owner's or operator's per diem payment rate as calculated in this Supplement.

ENCLOSURE **FOR STAKEHOLDERS ONLY

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

10-015*

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)
Supplement 4 to Attachment 4.19-D, page 1 (TN 08-010)	Supplement 4 to Attachment 4.19-D, page 1
Supplement 4 to Attachment 4.19-D, page 6 (TN 05-005)	Supplement 4 to Attachment 4.19-D, page 6
Supplement 4 to Attachment 4.19-D, pages 8-17 (TNs 05-005, 08-010, 09-020)	Supplement 4 to Attachment 4.19-D, pages 8-17
None	Supplement 4 to Attachment 4.19-D, pages 18-19