



TOBY DOUGLAS  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

NOV 29 2012

Gloria Nagle, PhD, MPA  
Associate Regional Administrator  
Centers for Medicare and Medicaid Services  
Division of Medicaid and Children's Health  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6707

STATE PLAN AMENDMENTS 11-010A and 11-010B

Dear Ms. Nagle,

The Department of Health Care Services (DHCS) is requesting to place State Plan Amendments (SPAs) 11-010A and 11-010B "back on the clock."

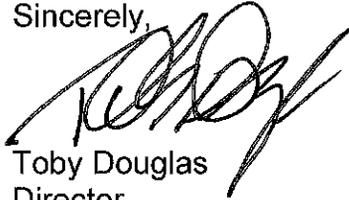
On June 4, 2012, DHCS took the SPAs "off the clock" to continue to work with the Centers for Medicare and Medicaid Services to provide responses to additional questions relating to Trigger Language included in both SPAs, as well as the changes to reimbursement methodologies and/or payment reductions in accordance with AB 97 (Statutes 2011).

Enclosed you will find the following:

- SPA pages for each of the SPAs noted above.
- Responses to the Request for Additional Information (RAI) dated September 27, 2011.
- HCFA 179 form.
- Spreadsheets supporting the estimated federal savings.
- Access Analyses for ICF/DD, ICF/DD-Habilitative and ICF/DD-Nursing; and Pediatric Subacute.

If you have any further questions regarding the SPAs or the RAI responses, please contact Mr. John Mendoza, Acting Chief, Fee-For-Service Rates Development Division, at (916) 552-9639.

Sincerely,



Toby Douglas  
Director

Enclosures

cc: Mr. Mark Wong  
Centers for Medicare and Medicaid Services  
Division of Medicaid and Children's Health  
90 7<sup>th</sup> Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6706

Ms. Carolyn Kenline  
Centers for Medicare and Medicaid Services  
Division of Medicaid and Children's Health  
90 7<sup>th</sup> Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6706

Mr. John Mendoza, Acting Chief  
Fee-For-Service Rates Development Division  
Department of Health Care Services  
1501 Capitol Avenue, Suite 41.7001  
MS 4601  
P.O. Box 997417  
Sacramento, CA 95899-7417

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

1. TRANSMITTAL NUMBER:  
11-010A

2. STATE  
CA

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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

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

4. PROPOSED EFFECTIVE DATE  
~~June 1, 2011~~ January 1, 2011  
*January 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:  
*AB97 42 CFR 447 Subpart C*

7. FEDERAL BUDGET IMPACT:  
a. FFY ~~2010-2011 2011-12~~  $\$ < 827,031 >$   $\$ < 1,770,400 >$   
b. FFY ~~2011-2012 2012-13~~  $\$ < 2,481,093 >$   $\$ < 2,371,200 >$

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
*Attachment 4.19-D Page 15.4b and 15.4c  
~~Pages 15.4b, 15.4b.1, 15.4b.2~~  
Page 15.4b.1*

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if Applicable):  
*Attachment 4.19-D Page 15.4b and 15.4c  
~~Page 15.4b~~  
Page 15.4b and 15.4c*

10. SUBJECT OF AMENDMENT:  
**Reduced payment rates as mandated by Assembly Bill 97**

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.

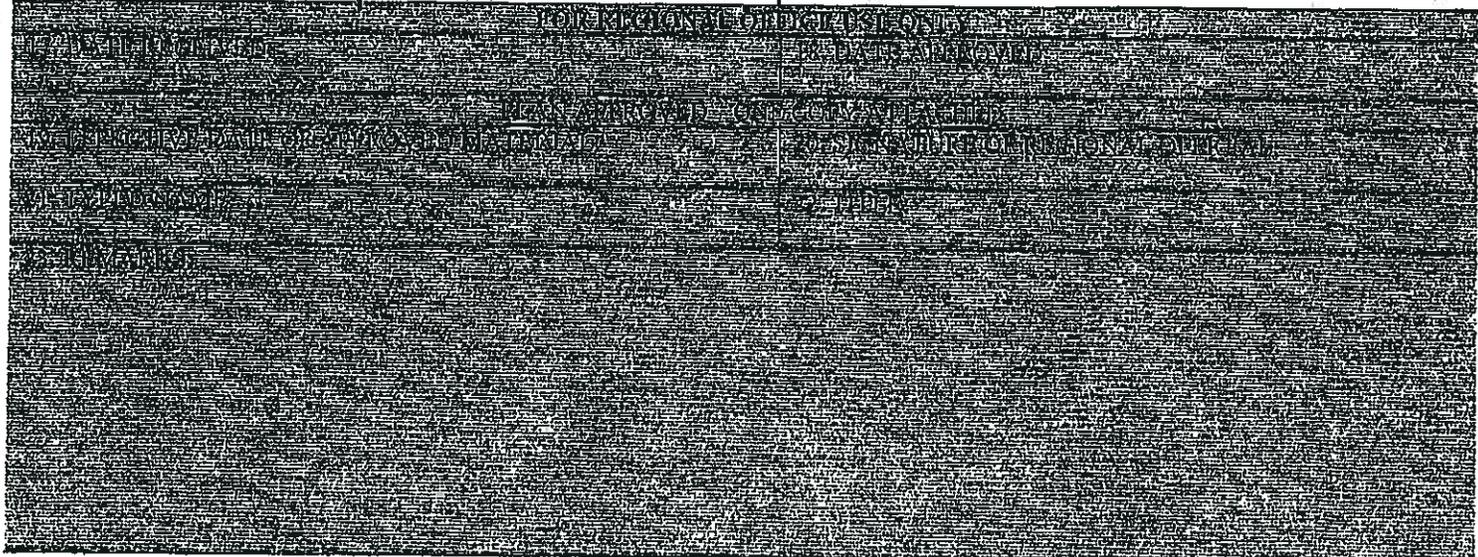
12. SIGNATURE OF STATE AGENCY OFFICIAL:  
*[Signature]*

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

13. TYPED NAME:  
*Toby Douglas*

14. TITLE:  
*Director*

15. DATE SUBMITTED:  
*12/22/11*



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

1. TRANSMITTAL NUMBER:  
11-010B

2. STATE  
CA

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

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

4. PROPOSED EFFECTIVE DATE

~~June 1, 2011~~ **JANUARY 1, 2011**  
**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:

AB97 42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:

a. FFY ~~2010-2011~~ 2011-12 \$ ~~(7,959,906)~~ **< 1,049,023**  
b. FFY ~~2011-2012~~ 2012-13 \$ ~~(23,879,718)~~ **< 4,383,680**  
**< 5,044,911**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D Page 15.4c.1 & 15.4c.2  
Pages ~~15.4c.1~~, 15.4c.1, 15.4c.2,  
15.4c.3 and 15.4c.4

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

Attachment 4.19-D Page 15.4c.1, 15.4c.2  
Page ~~15.4c~~  
**N/A**

10. SUBJECT OF AMENDMENT:

Reduced payment rates as mandated by Assembly Bill 97

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:

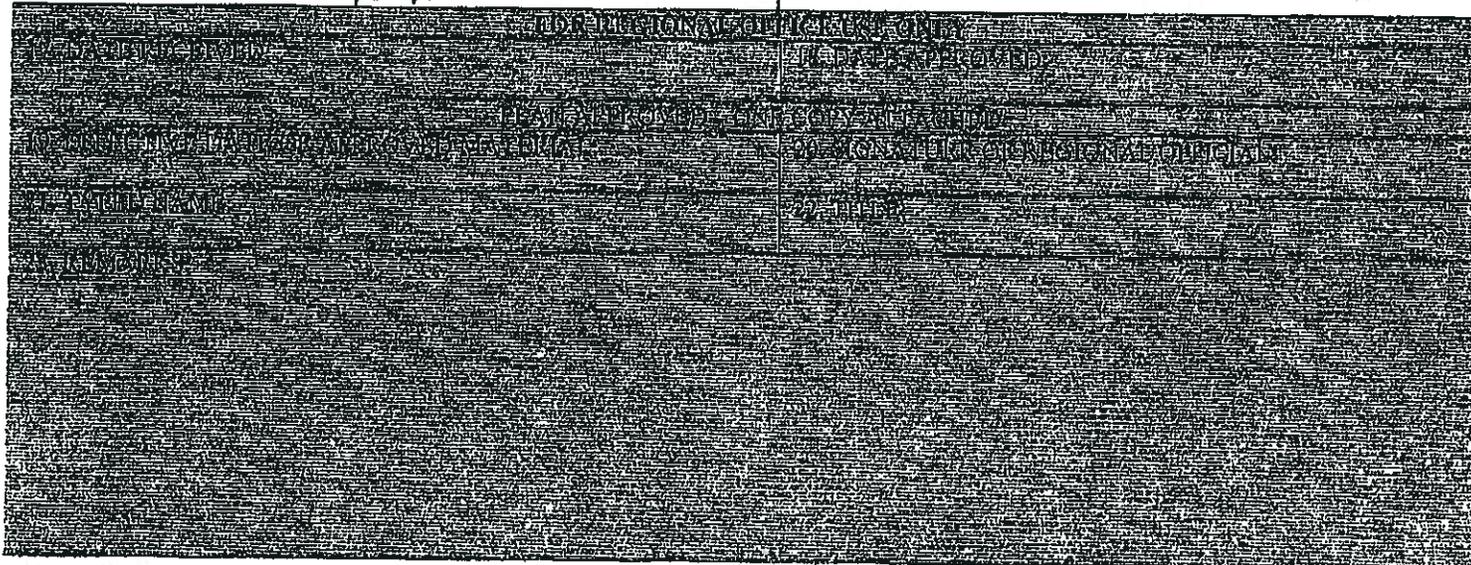
Director

15. DATE SUBMITTED:

12/22/11

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



SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
CMS and Corresponding DHCS Responses  
November 19, 2012

General:

- 1. Form HCFA-179, Box 6 - We request your permission to make pen-and-ink change to add in the regulatory citation "42 CFR 447 Subpart C."**

DHCS's Response: DHCS authorizes CMS to make the following pen-and-ink changes. Revised estimates are as follows:

- a. FFY 2011-2012 (\$ 1,049,023 – ICF/DDs) (\$1,778,400 – FS Ped Subs)
- b. FFY 2012--2013 (\$ 6,294,136 – ICF/DDs) (\$2,371,200 – FS Ped Subs)

- 2. Form HCFA-179, Box 7 - Please provide support/explanation for the fiscal impact amounts computed by the State.**

DHCS's Response: To calculate the above fiscal estimates for the ICF/DD providers (including Habilitative and Nursing), DHCS first determined the reimbursement rate for each of the providers under the proposed methodology and then compared the amount to the approved method. The difference between the amounts is the cost savings. The reimbursement rate for each provider under the proposed methodology will be one of the two rates listed below, as applicable:

- (a) The 2008-09 65<sup>th</sup> percentile for the facility's peer group, if the facility's total projected and adjusted costs increased by 5 percent are equal to or higher than the 2008-09 65<sup>th</sup> percentile. For purposes of this Section M, the 65<sup>th</sup> percentile will be based on the 2008-09 rate study.
- (b) The facility's total projected and adjusted costs increased by 5 percent, if the facility's total projected and adjusted costs increased by 5 percent are lower than the 2008-09 65<sup>th</sup> percentile; provided, however, that no facility will receive a rate that is lower than the 2008-09 65<sup>th</sup> percentile for its respective peer group, reduced by 10 percent.

To calculate the above fiscal estimates for the Freestanding Pediatric Subacute providers, DHCS compared what would have been paid to these providers with their rates set at the prospective rate for 2008-09, compared to the prospective rate for 2008-09 less 5.75%.

To obtain the estimated decrease for the Federal Fiscal Years (FFY) listed above, DHCS combined the total estimated costs for the periods August 1, 2012,

SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
CMS and Corresponding DHCS Responses  
November 19, 2012

through September 30, 2012, for FFY 2011-2012, and October 1, 2012, through  
September 30, 2013, for FFY 2012-2013.

**3. Section 1902(a)(30) of the Social Security Act requires that "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Please reply to the following questions regarding access to care:**

**a. How will the long term care payment reductions proposed by this SPA allow the State to comply with requirements of Section 1902(a)(30) of the Act? Please explain.**

DHCS's Response: Please refer to the "Monitoring Access to Medi-Cal Covered Healthcare Services" report (September 2011), and the comprehensive access monitoring plan that was incorporated in SPA 08-009B1 as Attachment 4.19-F, entitled "Measuring Access to Medi-Cal Covered Healthcare Services" (September 2011).

Please refer to the Medi-Cal Fee-For-Service Long-Term Care Access Analyses forwarded to CMS on November 3, 2011:

- Intermediate Care Facilities for the Developmentally Disabled.
- Pediatric Subacute Facilities.

**b. How did the State determine that the Medicaid long term care payments, with the long term care payment reductions proposed by this SPA, are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area?**

DHCS's Response: Please refer to response No. 3.a.

**c. What data did the State rely on to assure that access would not be negatively impacted by the long term care payment reductions proposed by this SPA (e.g., comparison with commercial access/reimbursement rates, comparison with Medicare rates, comparison with surrounding State Medicaid rates, comparison with national averages for Medicaid or Medicare)?**

DHCS's Response: Please refer to response No. 3.a.

**d. How were providers, advocates and beneficiaries engaged in the discussion around the long term care payment reductions proposed by this SPA? What were their concerns, and how did the State address these concerns?**

DHCS' Response: Legislative hearings were held for Assembly Bill 97 (Statutes of 2011) and notices were published to engage providers, advocates and beneficiaries. Concerns were expressed and considered in the legislative process. Providers were concerned with losing revenue and their ability to continue to provide access to care. For ICF/DDs, ICF/DD-Hs, and ICF/DD-Ns, DHCS modified the base reduction enacted in AB 97 in acknowledgement that an across-the-board 10 percent reduction to these types of facilities might create an impact on access. The revised reduction ensures access by providing that the facilities will receive reimbursement at 5 percent above projected costs not to exceed the 2008-09 65<sup>th</sup> percentile, but that no facility will receive less than the 2008-09 65<sup>th</sup> percentile, minus 10 percent.

In an effort to reduce the negative fiscal impact of the 10 percent payment reduction applicable under AB 97, California Association of Health Facilities (CAHF) representatives approached DHCS and proposed that the Pediatric Subacute providers pay a Quality Assurance Fee (QAF) in exchange for a lower payment reduction. DHCS worked cooperatively with CAHF to accomplish this after completing the Access Analysis for the Pediatric Subacute facilities, which showed that the Medi-Cal occupancy rates Freestanding (FS) Pediatric Subacute facilities had remained relatively constant and very high over the time period of the analysis. The analysis also demonstrated that if a reduction in beds provided by Distinct Part Pediatric Subacute facilities occurred that there would not be sufficient access in the freestanding facilities to absorb the service needs of the Medi-Cal population. Therefore, the decision was made to exempt the Distinct Part Pediatric Subacute facilities from the payment reduction, and reduce the Freestanding Pediatric Subacute facilities by 5.75 percent, and assess a QAF.

CAHF also expressed concerns that the FS Pediatric Subacute facilities will pay a QAF, with all proceeds going to the State, while simultaneously reducing the rates by 5.75 percent. DHCS explained that the QAF is a new cost/mandate, that the State is required to provide additional reimbursement to the providers for the costs of those mandates, with respect to providing

SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
CMS and Corresponding DHCS Responses  
November 19, 2012

services to Medi-Cal residents, and that DHCS will administer this program by providing additional reimbursement to the FS Pediatric Subacute facilities in the form of an “add-on” to the Medi-Cal per-diem rates to account for the additional cost of the QAF. In addition, DHCS explained that the FS Pediatric Subacute facilities will be reimbursed in advance the cost of any QAF payments that they will be required to make relative to Medi-Cal revenues. Under the QAF program, the FS Pediatric Subacute facilities receive a net reimbursement rate that will be higher than they would have received when subject to the base 10 percent reduction required by AB 97 – if the QAF program was not implemented.

- e. Is the State modifying anything else in the State Plan which will counterbalance impact on access that may be caused by the long term care payment reductions proposed by this SPA (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

DHCS's Response: The State is not modifying anything else in the State Plan other than what has been specifically identified in the text for SPAs 11-010A and 11-010B.

- f. How does the State intend to monitor the impact of the long term care payment reductions proposed by this SPA and implement a remedy should rates be insufficient to guarantee required access levels? Please provide specific details about the measures to be used, how these measures were developed, data sources, and plans for reporting, tracking and monitoring. The State should also provide the specific benchmarks for each measure which would trigger State action to remedy indicated access problems.**

DHCS's Response: Please refer to response No. 3.a.

- g. What action(s) does the State plan to implement after the long term care payment reductions/freeze proposed by this SPA takes place to counter any decrease to access?**

DHCS's Response: Please refer to response 3.a.

- 4. CMS has received numerous requests from various long term care providers, particularly from ICF/DD providers and distinct part providers, to**

SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
CMS and Corresponding DHCS Responses  
November 19, 2012

**disapprove this SPA. Providers have stated that such reductions will result in significant financial losses leading to change of services provided or closure of operations, reduced access of care for highly vulnerable patients, and/or severe decrease in quality of care. How is the State addressing these concerns?**

DHCS's Response: DHCS does not believe financial losses stated by providers will materialize. Please refer to the Department's Monitoring Access to Medi-Cal Covered Healthcare Services report. Going forward, the Department will implement the comprehensive access monitoring plan that was incorporated in SPA 08-009B1 as Attachment 4.19-F, entitled "Measuring Access to Medi-Cal Covered Healthcare Services."

The provider classes addressed in SPAs 11-010A and 11-010B are identified and rates payable to each facility type are listed below:

- ICF/DD, ICF/DD-H, and ICF/DD-N: The revised methodology proposal takes into consideration the providers' updated reported costs increased by 5 percent, which is the excess of their actual reported costs. If the facility's total projected costs, increased by 5 percent, are equal to or higher than the 2008-09 65<sup>th</sup> percentile, the applicable rate will be the 2008-09 65<sup>th</sup> percentile for the facility's peer group. If the facility's total projected costs, increased by 5 percent, are lower than the 2008-09 65<sup>th</sup> 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 65<sup>th</sup> percentile, reduced by 10 percent, for its respective peer group.
- Freestanding Pediatric Subacute: SPA 11-010A proposes a 5.75 percent payment reduction as opposed to a 10 percent reduction. In addition, please refer to the Medi-Cal Fee-For-Service Long-Term Care Access Analysis: Pediatric Subacute Facilities.
- Distinct Part Pediatric Subacute: No reduction.

In addition, DHCS revised the methodology in SPAs 11-010A and 11-010B to add trigger language to protect access to beneficiaries. The SPAs include the following triggers: (1) a decrease in number of licensed beds by 5 percent or more relative to when the reimbursement rate decrease took effect; and (2) an excess in occupancy levels equal to 98 percent or more. The triggers will be applicable to specified provider types on a statewide or geographical area basis,

SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
CMS and Corresponding DHCS Responses  
November 19, 2012

whichever applies in accordance with the SPA language. If either trigger becomes operational, DHCS will institute a per-diem rate for a 120 day review period for facilities statewide or in a geographical area, whichever is applicable, that will be equal to the per-diem reimbursement rate in effect for the 2008-09 rate year before considering further action based on the findings of the review.

**5. Please explain whether any litigation has been filed for the 10% reductions effective 6/1/2011 and whether any court-ordered injunction has been issued which would impact the implementation of the 10% reduction.**

DHCS's Response: In order by most recent listed first, following lawsuits were filed in which court-ordered injunctions were issued:

- California Hospital Association (CHA) filed a lawsuit challenging the 10 percent reduction at the rates established in 2008-2009, required by Assembly Bill (AB) 97. On December 28, 2011, the federal court issued a preliminary injunction. The Department is complying with the injunction according to its provisions.

The injunction applicable to AB 97 applies to Distinct Part Nursing Facilities - Level B.

- CHA filed a lawsuit challenging the 2009-10 rate freeze at the rates established in 2008-2009, required by ABx4 5. On February 24, 2010, the federal district court issued a preliminary injunction. The Department is complying with the injunction according to its provisions.

The injunction applicable to ABx4 5 applies to the following facilities:

- Distinct Part Nursing Facility - Level B
- Distinct Part Adult Subacute
- Distinct Part Pediatric Subacute

- California Pharmacists Association, *et. al* (including CHA), filed a lawsuit challenging the 5 percent reduction in the 2008-09 rates effective March 1, 2009, required by AB 1183. On April 6, 2009, the United States Court of Appeal for the Ninth Circuit issued a preliminary injunction. The Department is complying with the injunction according to its provisions.

The injunction applicable to AB 1183 applies to the following long-term care facilities:

- Distinct Part Nursing Facility - Level B
- Distinct Part Adult Subacute
- Distinct Part Pediatric Subacute

SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
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November 19, 2012

6. **Please explain any litigation and court orders concerning the rate freeze discussed in paragraph K.1 of the SPA and the five percent reduction discussed in paragraph K.2 of the SPA. The new 10% reduction effective 6/1/2011 is a 10% reduction of the frozen rate (in paragraph K.1). To the extent that there are court-ordered injunctions on the rate freeze, how will the State implement the new 10% reduction?**

DHCS's Response: As noted in response number 5, injunctions have been issued and DHCS is complying with each injunction according to its provisions. The injunction applicable to AB 97 does not apply to the following facilities:

- Freestanding Pediatric Subacute - (located in proposed SPA 11-010A)
- Nursing Facility Level A - (located in SPA 08-009D)
- ICF/DD - (located in proposed SPA 11-010B)
- ICF/DD-H - (located in proposed SPA 11-010B)
- ICF/DD-N - (located in proposed SPA 11-010B)
- Rural Swing Bed - (located in 08-009D, and 11-010A to revise pagination)
- Distinct Part Adult Subacute - (located in SPA 08-009D)
- Distinct Part Pediatric Subacute - (located in SPA 08-009D)

The injunction to ABx4 5 does not apply to the following facilities:

- Freestanding Pediatric Subacute - (located in proposed SPA 11-010A)
- Nursing Facility Level A - (located in SPA 08-009D)
- ICF/DD - (located in proposed SPA 11-010B)
- ICF/DD-H - (located in proposed SPA 11-010B)
- ICF/DD-N - (located in proposed SPA 11-010B)

The injunction to AB 1183 does not apply to the following facilities because there was no court ordered injunction:

- Freestanding Pediatric Subacute - (located in proposed SPA 11-010A)
- Nursing Facility Level A - (located in SPA 08-009D)
- ICF/DD - (located in proposed SPA 11-010B)
- ICF/DD-H - (located in proposed SPA 11-010B)
- ICF/DD-N - (located in proposed SPA 11-010B)

7. **This SPA affects pages 15.4 and 15.4a, which are part of pending SPAs 10-021 and 09-019. We will not be able to approve this SPA until 10-021 and 09-019 are resolved.**

DHCS's Response: The provisions of SPAs 09-019 and 10-021 were included in SPA 08-009D, which was subsequently approved by CMS on October 27, 2012.

SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
CMS and Corresponding DHCS Responses  
November 19, 2012

**State plan pages**

8. **Page 15.4a - paragraph 3: In the public notice, there is discussion regarding the 10% reduction being applicable to rural swing bed services and freestanding adult subacute services. How are these reductions accounted for here in this SPA? They are not included in the list in this paragraph.**

DHCS's Response: There are no plans to reduce reimbursement amounts for rural swing bed facilities. Reductions for freestanding adult subacute facilities are detailed in SPA 11-011.

9. **Page 15.4a - paragraph 4: Please explain what the exception for small and rural hospitals mean in this context of Attachment 4.19-D reimbursement. Is the State referring to swing bed services in these hospitals, or distinct parts in these hospitals? The State plan needs to clarify.**

DHCS's Response: Small and rural hospitals are not subject to the provisions of SPA 11-010B. The State will maintain the same payment methodology approved in Paragraph K.9 of SPA 08-009D (at page 15.4c).

The State has removed rural swing bed from the previously submitted SPA 11-010A, to reflect the State's intent to continue the payment methodology approved in Paragraph K.9 of SPA 08-009D. As noted above, the unaltered language pertaining to small and rural hospitals is located on page 15.4c of Attachment 4.19-D.

10. **Page 15.4a - paragraph 5: For freestanding pediatric subacutes, the reduction is 5.7% instead of 10%. To be consistent with preceding paragraphs, would it be appropriate to say that the 5.7% reduction is applicable to "the payments that would otherwise be paid for the services under subparagraph K.1" rather than "the rate on file as of May 31, 2011"? Is there a difference?**

DHCS's Response: The State has clarified this in SPA 11-010A. Attachment 4.19-D, page 15.4b, specifies the provider types to which the reductions apply. The reductions are summarized in response to question number 3.d on page 3.

11. **Page 15.4 - paragraph 5: Regarding the freestanding pediatric subacute reimbursement, the public notice refers to a new quality assurance fee as a funding source. Please explain this further. How exactly will freestanding**

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**pediatric subacute reimbursement be funded by this quality assurance fee? Will this quality assurance fee comply with all federal requirements on health care taxes, including broad-based, uniformity, and hold harmless provisions, or will waivers be requested?**

DHCS's Response: ABx1 9 (Statutes of 2011) removed the exemption for the Freestanding (FS) Pediatric Subacute facilities for paying the Quality Assurance Fee (QAF) assessed against FS Nursing Facilities (NF) Level B. The additional funds received in QAF revenues from the FS Pediatric Subacute facilities will affect DHCS' level of reimbursement to the FS Pediatric Subacute facilities. As a result of the additional funds received, instead of reducing provider payments by 10 percent, the net reduction will only be to reduce payments by 5.75 percent.

The QAF that the FS Pediatric Subacute facilities will be assessed under the current QAF program for the FS/NF Level Bs applicable to the 2011-12 rate year, which includes FS Adult Subacute facilities. This QAF program functions under a waiver of broad-basedness and uniformity, granted pursuant to 42 CFR 433.68(e), which is renewed annually. DHCS will submit a new waiver request relating to the QAF applicable to FS Pediatric Subacute facilities for the 2012-13 rate year.

**The following funding questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-D of your State plan.**

- 12. Section 1903(a) (1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers received and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

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DHCS's Response: Providers do not return any portion of payments (Federal or State share) to the State, any local governmental entity, or any other intermediary organization.

**13. Section 1902(a) (2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**

- I. - a complete list of the names of entities transferring or certifying funds;**
- II. - the operational nature of the entity (state, county, city, other);**
- III. - the total amounts transferred or certified by each entity;**
- IV. - clarify whether the certifying or transferring entity has general taxing authority;**
- V. - whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Below is the latest information available for Payments Funded by CPEs for Fiscal Year 2008-09. It is our understanding that the overall payment amount does not change significantly from one year to another.

Facility Name	Operational Nature	FFP (CPE based)	Taxing Authority	Received State Appropriations
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SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
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 November 19, 2012

Bear Valley Community Hospital D/P SNF	Health Care District	\$17,952.81	Health Care District has taxing authority	No
Catalina Island Medical Center D/P SNF	Non-Profit**	\$87,727.28	City has taxing authority	No
Edgemoor Geriatric Hospital	County	\$6,861,314.23	County has taxing authority	No
Hazel Hawkins Memorial Hospital	Health Care District	\$254,562.91	Health Care District has taxing authority	No
Kaweah Delta District Hospital D/P SNF	Health Care District	\$152,324.57	Health Care District has taxing authority	No
Laguna Honda Hospital & Rehabilitation CTR D/P SNF	County	\$9,947,721.26	County has taxing authority	No
San Francisco General Hospital D/P SNF	County	\$1,837,689.31	County has taxing authority	No
San Mateo (Crystal Springs) Medical Center D/P SNF	County	\$5,715,589.78	County has taxing authority	No
Sonoma Valley Hospital D/P SNF	Health Care District	\$30,268.28	Health Care District has	No

SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
 CMS and Corresponding DHCS Responses  
 November 19, 2012

			taxing authority	
Tahoe Forest Hospital D/P SNF	Health Care District	\$150,846.24	Health Care District has taxing authority	No

\* Figures were taken from claim schedules, provided by accounting, for DOP period FY 08/09

\*\* Owned by the City of Avalon

The reimbursement methodology for DP/NF-B providers include a rate system in which facilities are paid a rate set at the lower of the individual facility's projected cost or the median projected cost. The rates are based on each facility's annual or fiscal period closing cost report. All reported costs are adjusted based on audits of reported costs performed by the Department's Audits and Investigations Program. The adjusted costs are then projected forward to the upcoming rate year using various update factors. DHCS' BWARD provides DHCS' SNFD the DP/NF median and projected rates report for the upcoming Rate Year (RY), which lists the rates for the facilities participating in the DP/NF program. The participating facilities will then file supplemental claims for FFP. Submission of CPEs and resulting claims for FFP require documentation based on the facility's accounting records. The facility submits worksheets and other documents with its claim. DHCS reviews the claim for accuracy and completeness to ensure that the underlying documentation is sufficient to support the claim for Federal funds.

- 14. Section 1902(a) (30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

DHCS's Response: Assembly Bill 430 (2001) authorizes supplemental payments to DP/NF Level B facilities of a general acute care hospital that is owned or operated by a city, county, city and county or health care district, which meets specified requirements and provides nursing facility services to Medi-Cal beneficiaries. The supplemental or enhanced payments made to all provider types according to the 2008-2009 estimate for FFP is \$25,056,000.

SPAs 11-010A and 11-010B Request for Additional Information (RAI) Questions from  
CMS and Corresponding DHCS Responses  
November 19, 2012

- 15. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.**

DHCS's Response: Pursuant to discussion with CMS, the State has satisfied the requirement to demonstrate compliance with UPL demonstration.

- 16. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

DHCS's Response: No provider payment exceeds the provider's reasonable cost of providing services.

## **Medi-Cal Fee-For-Service Long-Term Care Access Analysis: Pediatric Subacute Facilities**

The California Department of Health Care Services (DHCS) developed this paper in conjunction with the Department's proposed State Plan Amendment to reduce Medi-Cal reimbursements to long-term care providers. This analysis includes the following Medi-Cal long-term care provider types:

- Freestanding Pediatric Subacute Facilities
- Distinct Part (Hospital Based) Pediatric Subacute Facilities

In this paper, DHCS presents an analysis of the state of access to these long term care services in the Medi-Cal fee-for-service (FFS) program.

### **Overview of Approach**

DHCS' assessment of the current state of access in Medi-Cal FFS is based on evaluating available audited data for long-term care services and focuses on measures that assess Medi-Cal provider availability and utilization. Specifically, our analysis covers four key measures:

- 1) total available providers compared to Medi-Cal participating providers;
- 2) the amount of Medi-Cal utilization as measured by the number of Medi-Cal days;
- 3) the ratio of Medi-Cal bed days to total bed days; and
- 4) vacancy rates of Medi-Cal providers.

Our assessment includes analyzing the identified data elements both statewide and by California's seven established county-based peer groups. This enabled DHCS to analyze the availability of providers and services both overall and drill down into smaller geographic regions.

As noted above, our analysis looks at providers and services that are freestanding and distinct part. DHCS has completed the analysis for these provider types separately. However, since freestanding and distinct part providers provide the same services, it is important to consider the overall availability of pediatric subacute services across the freestanding and distinct part providers.

### **Methodology**

#### ***Data Source***

For this assessment, DHCS used the best data currently available. The data for the analyses were collected for the most recent five year period for which audited data was available (2005 through 2009). Audited data provide the best source of valid information at the provider level of provider availability and utilization. The total Medi-Cal bed days and the total occupied bed days were based on facility-reported data to the Office of Statewide Planning and Development which was audited by the DHCS's Audits and Investigations program. The licensed bed days by facility type for each year were obtained from the California Department of Public Health's Licensing and Certification program.

## ***Geographic Peer Groups***

As a part of our analysis, DHCS looked at the key measures at both the statewide level and by peer group in order to drill down into provider availability and utilization at the local level. The geographic peer groups used for this analysis were originally created for setting Freestanding Skilled Nursing Facilities – Level B rates. The seven peer groups were developed for the purpose of clustering the Freestanding Skilled Nursing Facilities into county groupings with similar operating costs. Since direct care labor represents the majority of facility costs, direct care labor served as the basis for clustering the facilities. Specifically, the median per diem direct resident care labor cost for each individual county was subjected to a statistical clustering algorithm using commercially available statistical software. The statistical analysis of the county costs resulted in seven peer groups. Each county was also identified as being either “urban” or “rural” in order to statistically confirm that direct care costs are influenced by urban or rural status. Accordingly, each peer group contains only urban or rural counties. The resulting peer groups contain counties that are similar in nature and therefore provide an appropriate basis for analyzing provider availability and Medi-Cal utilization by geographic area. Appendix A contains the list of peer groups and the counties within each peer group. Appendix B contains a map that identifies the location of the counties in each peer group.

## ***Description of Measures***

DHCS chose the four measures included in this analysis based on available data and because they provide the best means of creating a picture of provider availability and Medi-Cal utilization.

- 1) Total available providers compared to Medi-Cal participating providers: Our analysis includes information on the total number of available providers and licensed beds (statewide and by peer group) as compared to the total number of Medi-Cal participation providers and licensed beds. We defined Medi-Cal participating provider as those facilities having at least one Medi-Cal bed day in the calendar year. This analysis allows us to determine the degree of Medi-Cal participation by all available providers. The analysis also looks at the changes in this measure over time.
- 2) Amount of Medi-Cal utilization: DHCS’ analysis included looking at total Medi-Cal utilization, as measured by Medi-Cal days, over time. This allows us to track trends in utilization and determine if utilization has increased or decreased, which could indicate potential issues with access or changes in the service needs of the population.
- 3) Ratio of Medi-Cal bed days to total bed days: Total Medi-Cal bed days were examined relative to total occupied bed days for each year, with respect to Medi-Cal participating facilities. This measure provides for an identification of any material fluctuations across the years included in the analysis in terms of the ratio of total Medi-Cal bed days to total bed days. This measure is important from the standpoint of indicating whether facilities might be refusing to admit additional Medi-Cal beneficiaries and gauging the extent to which Medi-Cal is important to a particular provider type.

- 4) Vacancy rates of Medi-Cal providers: Vacancy rates were calculated for each year to determine the extent to which capacity exists within each provider type and across provider types within each service category. This measure is particularly useful, since a high vacancy rate for a given provider type indicates that facilities comprising the provider type or service category will be more likely to continue to accept Medi-Cal beneficiaries following the implementation of reimbursement reductions. In addition, it is important to look at vacancy rates for the different provider types (freestanding and distinct part) who provide the same services in a particular service category. Analyzing freestanding and distinct part facilities separately allows us to determine whether a provider of the same service in the other provider type category might be able to absorb any potential reductions in provider availability.

Vacancy rates are also useful from the standpoint of gauging the extent to which rates are reimbursing for the costs associated with vacant beds. In order to not subsidize vacant beds, some states set their Medicaid per-diem rates on the basis of minimum occupancy levels. Ohio, for example, sets its rates on the basis of a 90 percent occupancy level. Vacancy rates were calculated by dividing the total occupied bed days for each year by the total available bed days for the year. The total available bed days for the year were estimated by multiplying the total licensed beds for the year times 365.

## **State of Access in Medi-Cal FFS**

### ***Summary of Results***

#### **Freestanding Pediatric Subacute & Distinct Part Pediatric Subacute**

The analysis indicates 100% of all providers of pediatric subacute services (both freestanding and distinct part) participate in the Medi-Cal program. Overall Medi-Cal utilization of pediatric subacute services has increased over time in both freestanding and distinct part facilities. Medi-Cal occupancy rates have not changed significantly over time and vacancy rates continue to indicate sufficient capacity for Medi-Cal patients. The originally proposed reductions for these providers were different based on the decision of the freestanding pediatric providers to elect to provide the state with a quality assurance fee (QAF) that allowed for additional payment to be made to those providers to reduce the reduction to 5.75 percent. The analysis also demonstrates that if a reduction in beds provided by distinct part pediatric subacute providers occurred that there would not be sufficient access in the freestanding facilities to absorb the service needs of the Medi-Cal population.

The analyses of provider availability and utilization contained in this paper combined with the differences in reimbursement methodologies for these providers have led California to conclude that the originally proposed freeze and 5.75% reduction for freestanding pediatric subacute facilities will not impede access as these providers negotiated this level of reduction with the legislature and the Brown Administration. However, California will not be moving forward with the proposed freeze and 10% reduction for distinct part pediatric subacute providers as there is the potential that there would not be sufficient bed capacity if these facilities were to stop participating in Medi-Cal.

## Detailed Analysis

This section contains the detailed analysis of the pediatric subacute services being reviewed in this paper. The tables contained in this section provide data on the key measures used in the analysis both statewide and by the geographic peer groups.

### Pediatric Subacute Services: Freestanding & Distinct Part

#### Statewide Analysis

The tables below present the analysis of the provider availability of pediatric subacute services and the Medi-Cal utilization of those services on a statewide basis.

**Table 1: Freestanding Pediatric Subacute Facilities: Statewide Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	5	242	5	242	88,330	66,584	21,746	24.62%	63,032	94.7%	71.4%	100.0%	100.0%
2006	5	252	5	252	91,980	78,385	13,595	14.78%	75,797	96.7%	82.4%	100.0%	100.0%
2007	5	252	5	252	91,980	81,740	10,240	11.13%	79,530	97.3%	86.5%	100.0%	100.0%
2008	5	246	5	246	89,790	81,317	8,473	9.44%	77,433	95.2%	86.2%	100.0%	100.0%
2009	5	246	5	246	89,790	82,629	7,161	7.98%	78,829	95.4%	87.8%	100.0%	100.0%

**Table 2: Distinct Part Pediatric Subacute Facilities: Statewide Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	5	114	5	114	41,610	31,038	10,572	25.41%	16,902	54.5%	40.6%	100.0%	100.0%
2006	5	132	5	132	48,180	35,168	13,012	27.01%	19,866	56.5%	41.2%	100.0%	100.0%
2007	5	110	5	110	40,150	37,431	2,719	6.77%	21,858	58.4%	54.4%	100.0%	100.0%
2008	5	119	5	119	43,435	39,593	3,842	8.85%	24,489	61.9%	56.4%	100.0%	100.0%
2009	5	126	5	126	45,990	42,040	3,950	8.59%	24,279	57.8%	52.8%	100.0%	100.0%

As tables 1 and 2 demonstrate, statewide participation of both freestanding and distinct part facilities has been 100% for the entire time period. Additionally, the number of licensed beds in these facilities has remained relative constant over the time period with some slight fluctuations. The overall number of facilities is relatively small with both freestanding and distinct part facilities having 5 providers.

The level of Medi-Cal occupancy rates in freestanding facilities has remained relatively constant and very high over the time period in this analysis. This result indicates a continued willingness and ability by freestanding providers to treat the Medi-Cal population. The Medi-Cal occupancy rate for distinct part facilities has also remained relatively constant, although these facilities have significantly less Medi-Cal occupancy rates than freestanding providers indicating a smaller level of participation. Additionally, although vacancy rates have declined over time, the vacancy rates in both types of facilities continue to remain relatively high indicating that there would likely be sufficient capacity for additional patients, although for distinct part facilities given the current

lower Medi-Cal occupancy rates, it is likely that the additional capacity may be more likely to be utilized by other patient types.

Medi-Cal utilization as measured by the number of bed days in both facilities has grown somewhat over the 5 year period, although has remained relatively constant over the last two years in the analysis.

Based on the analysis, particularly the difference in willingness to accept Medi-Cal patients as measured by Medi-Cal occupancy, the lack of capacity in freestanding facilities to absorb a loss of the distinct part facilities, and the differences in reimbursement structure, California had determined that the proposed reduction to freestanding facilities can occur without impeding access but has decided to withdraw the proposed reduction to distinct part facilities.

### Geographic Peer Group Analysis

In the following tables we layout the same information included in the statewide analysis by each of the geographic peer groups. Given the small number of facilities, these types of facilities only exist in 3 of the county-based groups.

#### Peer Group 5

**Table 3: Freestanding Pediatric Subacute Facilities: Peer Group 5 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	2	123	2	123	44,895	31,558	13,337	29.71%	29,928	94.8%	66.7%	100.0%	100.0%
2006	2	123	2	123	44,895	38,771	6,124	13.64%	37,472	96.6%	83.5%	100.0%	100.0%
2007	2	123	2	123	44,895	40,651	4,244	9.45%	39,623	97.5%	88.3%	100.0%	100.0%
2008	2	117	2	117	42,705	40,226	2,479	5.80%	38,449	95.6%	90.0%	100.0%	100.0%
2009	2	117	2	117	42,705	39,560	3,145	7.36%	38,743	97.9%	90.7%	100.0%	100.0%

**Table 4: Distinct Part Pediatric Subacute Facilities: Peer Group 5 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	1	22	1	22	8,030	4,973	3,057	38.07%	4,742	95.4%	59.1%	100.0%	100.0%
2006	1	22	1	22	8,030	7,674	356	4.43%	7,606	99.1%	94.7%	100.0%	100.0%
2007	1	22	1	22	8,030	7,928	102	1.27%	7,660	96.6%	95.4%	100.0%	100.0%
2008	1	22	1	22	8,030	7,804	226	2.81%	7,714	98.8%	96.1%	100.0%	100.0%
2009	1	22	1	22	8,030	7,856	164	2.04%	7,489	95.2%	93.3%	100.0%	100.0%

Peer Group 6

**Table 5: Freestanding Pediatric Subacute Facilities: Peer Group 6 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	2	83	2	83	30,295	23,226	7,069	23.33%	22,180	95.5%	73.2%	100.0%	100.0%
2006	2	93	2	93	33,945	27,204	6,741	19.86%	26,499	97.4%	78.1%	100.0%	100.0%
2007	2	93	2	93	33,945	28,605	5,340	15.73%	27,978	97.8%	82.4%	100.0%	100.0%
2008	2	93	2	93	33,945	28,417	5,528	16.29%	27,101	95.4%	79.8%	100.0%	100.0%
2009	2	93	2	93	33,945	30,598	3,347	9.86%	29,130	95.2%	85.8%	100.0%	100.0%

**Table 6: Distinct Part Pediatric Subacute Facilities: Peer Group 6 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	3	70	3	70	25,559	18,547	7,003	27.41%	5,877	31.7%	23.0%	100.0%	100.0%
2006	3	88	3	88	32,120	19,821	12,299	38.29%	5,473	27.6%	17.0%	100.0%	100.0%
2007	3	66	3	66	24,090	22,656	1,434	5.95%	8,019	35.4%	33.3%	100.0%	100.0%
2008	3	75	3	75	27,375	24,022	3,353	12.25%	9,507	39.6%	34.7%	100.0%	100.0%
2009	3	80	3	80	29,200	25,699	3,501	11.99%	9,001	35.0%	30.8%	100.0%	100.0%

Peer Group 7

**Table 7: Freestanding Pediatric Subacute Facilities: Peer Group 7 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	1	36	1	36	13,140	11,800	1,340	10.20%	10,924	92.6%	83.1%	100.0%	100.0%
2006	1	36	1	36	13,140	12,410	730	5.56%	11,826	95.3%	90.0%	100.0%	100.0%
2007	1	36	1	36	13,140	12,484	656	4.99%	11,929	95.6%	90.8%	100.0%	100.0%
2008	1	36	1	36	13,140	12,674	466	3.55%	11,883	93.8%	90.4%	100.0%	100.0%
2009	1	36	1	36	13,140	12,471	669	5.09%	10,956	87.9%	83.4%	100.0%	100.0%

**Table 8: Distinct Part Pediatric Subacute Facilities: Peer Group 7 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	1	22	1	22	8,030	7,518	512	6.38%	6,283	83.6%	78.2%	100.0%	100.0%
2006	1	22	1	22	8,030	7,673	357	4.45%	6,787	88.5%	84.5%	100.0%	100.0%
2007	1	22	1	22	8,030	6,847	1,183	14.73%	6,179	90.2%	76.9%	100.0%	100.0%
2008	1	22	1	22	8,030	7,767	263	3.28%	7,268	93.6%	90.5%	100.0%	100.0%
2009	1	24	1	24	8,760	8,475	285	3.25%	7,789	91.9%	88.9%	100.0%	100.0%

**Appendix A: Geographic Peer Group Listing**

*Peer groups with pediatric subacute facilities are indicated in bold.*

*Peer Group 1 (Rural)*

Colusa  
Del Norte  
Imperial  
Kern  
Kings  
Lake  
Lassen  
Tulare  
Yuba

*Peer Group 2 (Rural)*

Butte  
Humboldt  
Inyo  
Madera  
Merced  
San Luis Obispo  
Tehama  
Yolo

*Peer Group 3 (Rural)*

Calaveras  
Glenn  
Plumas  
San Joaquin  
Shasta  
Siskiyou  
Sutter  
Ventura

*Peer Group 4 (Rural)*

Amador  
El Dorado  
Nevada  
Placer  
Tuolumne

*Peer Group 5 (Urban)*

**Los Angeles**

*Peer Group 6 (Urban)*

**Fresno**  
**Orange**  
**Riverside**  
**San Bernardino**  
**San Diego**  
**Santa Cruz**  
**Solano**

*Peer Group 7 (Urban)*

**Alameda**  
**Contra Costa**  
**Marin**  
**Monterey**  
**Napa**  
**Sacramento**  
**San Francisco**  
**San Mateo**  
**Santa Barbara**  
**Santa Clara**  
**Sonoma**

*Peer Group Other (Rural)*

Mariposa  
Modoc  
San Benito  
Trinity



## **Medi-Cal Fee-For-Service Long-Term Care Access Analysis: Intermediate Care Facilities for the Developmentally Disabled**

The California Department of Health Care Services (DHCS) developed this paper in conjunction with the Department's proposed State Plan Amendment to reduce Medi-Cal reimbursements to long-term care providers. This analysis includes the following Medi-Cal long-term care provider types:

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

In this paper, DHCS presents an analysis of the state of access to these long term care services in the Medi-Cal fee-for-service (FFS) program.

### **Overview of Approach**

DHCS' assessment of the current state of access in Medi-Cal FFS is based on evaluating available data for long-term care services and focuses on measures that assess Medi-Cal provider availability and utilization. Specifically, our analysis targets four key measures calculated using the best available data (please see Methodology section for description of how these measures are operationalized for the 3 different types of ICF-DD facilities contained in this analysis):

- 1) total available providers compared to Medi-Cal participating providers;
- 2) the amount of Medi-Cal utilization as measured by the number of Medi-Cal days;
- 3) the ratio of Medi-Cal bed days to total bed days; and
- 4) vacancy rates of Medi-Cal providers.

Our assessment includes analyzing the identified data elements both statewide and by California's seven established county-based peer groups. This enabled DHCS to analyze the availability of providers and services both overall and drill down into smaller geographic regions.

As noted above, our analysis looks at the three different types of ICF-DD facilities independently. However, the rate methodology is the same for all three facilities.

### **Methodology**

#### ***Data Source***

For this assessment, DHCS used the best data currently available. The data for the analyses were cost report data collected for the most recent four period for which data was available (2005 through 2008). Cost report data provide the best source of valid information at the provider level of provider availability and utilization. The total Medi-Cal bed days and the total occupied bed days for ICF-DD providers were based on facility-reported data to the Office of Statewide Planning and Development which was audited by the DHCS's Audits and Investigations program. The licensed bed days for ICF-DD providers for each year were obtained from the California Department of Public Health's Licensing and Certification program. The licensed bed days and

total occupied bed days for ICF-DD/H and ICF-DD/N providers were obtained from facility-reported cost reports submitted to the California Department of Health Care Services.

### ***Geographic Peer Groups***

As a part of our analysis, DHCS looked at the key measures at both the statewide level and by peer group in order to drill down into provider availability and utilization at the local level. The geographic peer groups used for this analysis were originally created for setting Freestanding Skilled Nursing Facilities – Level B rates. The seven peer groups were developed for the purpose of clustering the Freestanding Skilled Nursing Facilities into county groupings with similar operating costs. Since direct care labor represents the majority of facility costs, direct care labor served as the basis for clustering the facilities. Specifically, the median per diem direct resident care labor cost for each individual county was subjected to a statistical clustering algorithm using commercially available statistical software. The statistical analysis of the county costs resulted in seven peer groups. Each county was also identified as being either “urban” or “rural” in order to statistically confirm that direct care costs are influenced by urban or rural status. Accordingly, each peer group contains only urban or rural counties. The resulting peer groups contain counties that are similar in nature and therefore provide an appropriate basis for analyzing provider availability and Medi-Cal utilization by geographic area. Appendix A contains the list of peer groups and the counties within each peer group. Appendix B contains a map that identifies the location of the counties in each peer group.

### ***Description of Measures***

DHCS targeted the four measures included in this analysis based on available data and because they provide the best means of creating a picture of provider availability and Medi-Cal utilization, these measures are consistent with the analyses completed by DHCS for other long-term care provider types. As noted below, certain measures had to be modified or were not available for the ICF-DD/H and ICF-DD/N providers.

- 1) Total available providers compared to Medi-Cal participating providers: Our analysis includes information on the total number of available providers and licensed beds (statewide and by peer group) as compared to the total number of Medi-Cal participation providers and licensed beds. We defined Medi-Cal participating provider as those facilities having at least one Medi-Cal bed day in the calendar year. This analysis allows us to determine the degree of Medi-Cal participation by all available providers. The analysis also looks at the changes in this measure over time. Although Medi-Cal specific utilization was not available for the ICF-DD/H and ICF-DD/N providers, we know from other information sources that all ICF-DD/H and ICF-DD/N providers are Medi-Cal providers.
- 2) Amount of Medi-Cal utilization: DHCS’ analysis included looking at total Medi-Cal utilization, as measured by Medi-Cal days, over time. This allows us to track trends in utilization and determine if utilization has increased or decreased, which could indicate potential issues with access or changes in the service needs of the population. For ICF-DD/H and ICF-DD/N providers, the submitted cost reports do not break out Medi-Cal bed days from total bed days, however from other sources of information and the providers

themselves we know that over 99% of utilization in these facilities is for Medi-Cal beneficiaries.

- 3) Ratio of Medi-Cal bed days to total bed days: Total Medi-Cal bed days were examined relative to total occupied bed days for each year, with respect to Medi-Cal participating facilities. This measure provides for an identification of any material fluctuations across the years included in the analysis in terms of the ratio of total Medi-Cal bed days to total bed days. This measure is important from the standpoint of indicating whether facilities might be refusing to admit additional Medi-Cal beneficiaries and gauging the extent to which Medi-Cal is important to a particular provider type. This measure is not available for the ICF-DD/H and ICF-DD/N providers given the data available as noted above.
- 4) Vacancy rates of Medi-Cal providers: Vacancy rates were calculated for each year to determine the extent to which capacity exists within each provider type and across provider types within each service category. This measure is particularly useful, since a high vacancy rate for a given provider type indicates that facilities comprising the provider type or service category will be more likely to continue to accept Medi-Cal beneficiaries following the implementation of reimbursement reductions.

Vacancy rates are also useful from the standpoint of gauging the extent to which rates are reimbursing for the costs associated with vacant beds. In order to not subsidize vacant beds, some states set their Medicaid per-diem rates on the basis of minimum occupancy levels. Ohio, for example, sets its rates on the basis of a 90 percent occupancy level. Vacancy rates were calculated by dividing the total occupied bed days for each year by the total available bed days for the year. The total available bed days for the year were estimated by multiplying the total licensed beds for the year times 365.

### **Background on Rate Setting**

ICF-DD rates for the three types of facilities are set based on the facility reported costs contained in the cost reports. The cost information is utilized to determine the 65<sup>th</sup> percentile by each of the types of facility and by bed size creating six different rate categories as follows:

1. ICF-DD/H facilities with 4 to 6 beds
2. ICF-DD/H facilities with 7 to 15 beds
3. ICF-DD/N facilities with 4 to 6 beds
4. ICF-DD/N facilities with 7 to 15 beds
5. ICF-DD facilities with 1 to 59 beds
6. ICF-DD facilities with 60+ beds

All facilities within each type/bed size combination are then paid at the 65<sup>th</sup> percentile rate for their category.

## State of Access in Medi-Cal FFS

### *Summary of Results*

#### ICF-DD/H, ICF-DD/N and ICF-DD Facilities

The analysis indicates that 100% of all three types of ICF-DD participate in the Medi-Cal program. Overall Medi-Cal utilization of these types of facilities has fluctuated somewhat for ICF/DD-H and ICF-DD/N facilities although it has generally remained within a fairly consistent range. Utilization for ICF-DD facilities has seen somewhat of a decline. Vacancy rates in ICF-DD/H and ICF-DD/N facilities have generally remained around 5-7% over the four year period, indicating some additional capacity remains. Vacancy rates have been higher for ICF-DD facilities, remaining fairly constant at around 10%, indicating significant additional capacity.

The analyses of provider availability and utilization contained in this paper combined with how rates are currently determined led California to develop an alternative method of implementing the rate reduction. The revised rate reduction proposal takes into account a provider's reported cost compared to the 65<sup>th</sup> percentile, provides protections against immediate significant reductions above the originally proposed 10%, and establishes a glide path over a three year period that will eventually lead to incorporating each provider's own specific cost of providing services into their reimbursement rate. A brief summary of the revised reduction proposal is contained in the Revised Reduction Proposal section at the end of this paper.

#### *Detailed Analysis*

This section contains the detailed analysis of the ICF-DD services being reviewed in this paper. The tables contained in this section provide data on the key measures used in the analysis both statewide and by the geographic peer groups for each of the facility types.

#### ICF-DD/H, ICF-DD/N and ICF-DD Services

##### *Statewide Analysis*

The tables below present the analysis of the provider availability of ICF-DD facilities and the Medi-Cal utilization of those services on a statewide basis.

**Table 1: ICF-DD/H Facilities: Statewide Provider Availability & Medi-Cal Utilization**

<b>Year</b>	<b>Number of Facilities</b>	<b>Total Licensed Beds</b>	<b>Total Available Bed Days</b>	<b>Total Bed Days</b>	<b>Occupancy Rate</b>
2005	701	4,356	1,589,940	1,513,787	95.21%
2006	718	4,434	1,618,410	1,488,909	92.00%
2007	721	4,442	1,621,330	1,539,034	94.92%
2008	704	4,352	1,588,480	1,490,027	93.80%

*Note: For these facilities nearly all patients are Medi-Cal beneficiaries.*

**Table 2: ICF-DD/N Facilities: Statewide Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	300	1,845	673,425	624,288	92.70%
2006	313	1,915	698,975	648,288	92.75%
2007	333	2,037	743,505	681,223	91.62%
2008	328	1,985	724,525	673,975	93.02%

Note: For these facilities nearly all patients are Medi-Cal beneficiaries.

**Table 3: ICF-DD Facilities: Statewide Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	12	1,037	12	1,037	378,505	347,200	31,305	8.27%	342,108	98.5%	90.4%	100.0%	100.0%
2006	12	1,037	12	1,037	378,505	339,127	39,378	10.40%	335,154	98.8%	88.5%	100.0%	100.0%
2007	11	938	11	938	342,370	309,556	32,814	9.58%	306,398	99.0%	89.5%	100.0%	100.0%
2008	10	882	10	882	321,930	289,735	32,195	10.00%	287,294	99.2%	89.2%	100.0%	100.0%

As the tables above demonstrate, statewide participation of all three types of facilities has been 100% for the entire time period. Additionally, the number of licensed beds in these facilities has remained relative constant over the time period with some slight fluctuations. The overall number of facilities has declined somewhat over the final 2 years of the analysis.

The Medi-Cal occupancy rates for all three facilities are extremely high, with essentially all bed days in these facilities being occupied by Medi-Cal beneficiaries. The vacancy rates in these facilities differ by the facility type, with ICF-DD/H and ICF-DD/N facilities having vacancy rates that have remained around 6% with some slight variations, though still high enough to indicate some additional capacity remains for Medi-Cal beneficiaries. The vacancy rates in ICF-DD facilities are higher, remaining around 10% over the four year period indicating substantial capacity remains.

Medi-Cal utilization as measured by total bed days for the ICF-DD/H and ICF-DD/N facilities has seen some fluctuations over the four year period. For the ICF-DD/H facilities the utilization has varied by no more than 5% from the average over the four year period and for ICF-DD/N facilities the utilization has varied by no more than 2% over the period. Medi-Cal utilization in ICF-DD facilities has seen a fairly significant decline over the final 2 years of the analysis period due to the reduction in the number of providers, however as noted above the remaining providers continue to have significant vacancy rates indicating an ability to take on additional patients.

Based on this analysis, given some of the fluctuations seen in utilization and number of providers, California determined that the across the board 10% reduction would not be appropriate and might impact access. A revised reduction proposal that targeted reductions on facilities where reimbursement was exceeding cost was developed and as described in the later section provides protection and time for those facilities with significantly lower cost than the 65<sup>th</sup> percentile to prepare for the changes in reimbursement.

## ***Geographic Peer Group Analysis***

In the following tables we layout the same information included in the statewide analysis by each of the geographic peer groups. The results by geographic area generally follow the aggregate statewide results and support California's decision to modify the payment reduction to target the reduction on those facilities being paid more than cost.

### ***Peer Group 1***

**Table 4: ICF-DD/H Facilities Peer Group 1 Provider Availability & Medi-Cal Utilization**

<b>Year</b>	<b>Number of Facilities</b>	<b>Total Licensed Beds</b>	<b>Total Available Bed Days</b>	<b>Total Bed Days</b>	<b>Occupancy Rate</b>
2005	39	234	85,410	80,201	93.90%
2006	39	234	85,410	67,424	78.94%
2007	38	228	83,220	79,742	95.82%
2008	39	234	85,410	77,896	91.20%

**Table 5: ICF-DD/N Facilities Peer Group 1 Provider Availability & Medi-Cal Utilization**

<b>Year</b>	<b>Number of Facilities</b>	<b>Total Licensed Beds</b>	<b>Total Available Bed Days</b>	<b>Total Bed Days</b>	<b>Occupancy Rate</b>
2005	34	204	74,460	71,242	95.68%
2006	35	210	76,650	71,687	93.53%
2007	36	216	78,840	75,158	95.33%
2008	31	186	67,890	63,508	93.55%

There are no ICF-DD facilities in Peer Group 1 counties.

### ***Peer Group 2***

**Table 6: ICF-DD/H Facilities Peer Group 2 Provider Availability & Medi-Cal Utilization**

<b>Year</b>	<b>Number of Facilities</b>	<b>Total Licensed Beds</b>	<b>Total Available Bed Days</b>	<b>Total Bed Days</b>	<b>Occupancy Rate</b>
2005	20	120	43,800	42,141	96.21%
2006	18	108	39,420	36,295	92.07%
2007	20	120	43,800	41,277	94.24%
2008	13	78	28,470	24,922	87.54%

**Table 7: ICF-DD/N Facilities Peer Group 2 Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	26	165	60,225	54,246	90.07%
2006	32	201	73,365	62,262	84.87%
2007	30	189	68,985	63,482	92.02%
2008	24	153	55,845	51,499	92.22%

**Table 8: ICF-DD Facilities Peer Group 2 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	1	59	1	59	21,535	21,092	443	2.06%	21,092	100.00%	97.94%	100.00%	100.00%
2006	1	59	1	59	21,535	20,912	623	2.89%	20,912	100.00%	97.11%	100.00%	100.00%
2007	1	59	1	59	21,535	20,686	849	3.94%	20,655	99.85%	95.91%	100.00%	100.00%
2008	1	59	1	59	21,535	21,056	479	2.22%	20,690	98.26%	96.08%	100.00%	100.00%

*Peer Group 3*

**Table 9: ICF-DD/H Facilities Peer Group 3 Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	51	345	125,925	112,691	89.49%
2006	52	349	127,385	120,942	94.94%
2007	55	360	131,400	120,954	92.05%
2008	52	349	127,385	122,846	96.44%

**Table 10: ICF-DD/N Facilities Peer Group 3 Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	33	207	75,555	67,337	89.12%
2006	28	175	63,875	59,471	93.11%
2007	35	217	79,205	70,247	88.69%
2008	35	217	79,205	74,526	94.09%

There are no ICF-DD facilities in Peer Group 3 counties.

Peer Group 4

**Table 11: ICF-DD/H Facilities Peer Group 4 Provider Availability & Medi-Cal Utilization**

<b>Year</b>	<b>Number of Facilities</b>	<b>Total Licensed Beds</b>	<b>Total Available Bed Days</b>	<b>Total Bed Days</b>	<b>Occupancy Rate</b>
2005	2	12	4,380	4,380	100.00%
2006	2	12	4,380	4,242	96.85%
2007	2	12	4,380	4,380	100.00%
2008	2	12	4,380	4,142	94.57%

**Table 12: ICF-DD/N Facilities Peer Group 4 Provider Availability & Medi-Cal Utilization**

<b>Year</b>	<b>Number of Facilities</b>	<b>Total Licensed Beds</b>	<b>Total Available Bed Days</b>	<b>Total Bed Days</b>	<b>Occupancy Rate</b>
2005	4	24	8,760	8,736	99.73%
2006	4	24	8,760	8,671	98.98%
2007	4	24	8,760	8,468	96.67%
2008	4	24	8,760	8,180	93.38%

There are no ICF-DD facilities in Peer Group 4 counties.

Peer Group 5

**Table 13: ICF-DD/H Facilities Peer Group 5 Provider Availability & Medi-Cal Utilization**

<b>Year</b>	<b>Number of Facilities</b>	<b>Total Licensed Beds</b>	<b>Total Available Bed Days</b>	<b>Total Bed Days</b>	<b>Occupancy Rate</b>
2005	166	1,038	378,870	361,913	95.52%
2006	173	1,067	389,455	370,395	95.11%
2007	177	1,091	398,215	380,872	95.64%
2008	163	1,010	368,650	346,185	93.91%

**Table 14: ICF-DD/N Facilities Peer Group 5 Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	54	334	121,910	106,933	87.71%
2006	64	390	142,350	131,443	92.34%
2007	59	371	135,415	124,923	92.25%
2008	60	366	133,590	122,626	91.79%

**Table 15: ICF-DD Facilities Peer Group 5 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)								Provider Participation		
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	6	560	6	560	204,400	181,776	22,624	11.07%	179,942	98.99%	88.03%	100.00%	100.00%
2006	6	560	6	560	204,400	178,820	25,580	12.51%	177,743	99.40%	86.96%	100.00%	100.00%
2007	6	560	6	560	204,400	179,243	25,157	12.31%	178,451	99.56%	87.30%	100.00%	100.00%
2008	6	560	6	560	204,400	178,610	25,790	12.62%	178,114	99.72%	87.14%	100.00%	100.00%

Peer Group 6

**Table 16: ICF-DD/H Facilities Peer Group 6 Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	323	1,978	721,970	695,354	96.31%
2006	324	1,987	725,255	656,499	90.52%
2007	317	1,944	709,560	675,845	95.25%
2008	319	1,952	712,480	671,781	94.29%

**Table 17: ICF-DD/N Facilities Peer Group 6 Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	98	605	220,825	215,717	97.69%
2006	104	639	233,235	218,136	93.53%
2007	111	673	245,645	221,331	90.10%
2008	118	705	257,325	241,083	93.69%

**Table 18: ICF-DD Facilities Peer Group 6 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	3	303	3	303	110,595	103,731	6,864	6.21%	101,961	98.29%	92.19%	100.00%	100.00%
2006	3	303	3	303	110,595	99,509	11,086	10.02%	97,350	97.83%	88.02%	100.00%	100.00%
2007	2	204	2	204	74,460	69,132	5,328	7.16%	68,014	98.38%	91.34%	100.00%	100.00%
2008	2	204	2	204	74,460	68,588	5,872	7.89%	67,375	98.23%	90.48%	100.00%	100.00%

*Peer Group 7*

**Table 19: ICF-DD/H Facilities Peer Group 7 Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	99	623	227,395	214,917	94.51%
2006	109	671	244,915	230,922	94.29%
2007	112	687	250,755	235,952	94.10%
2008	116	717	261,705	242,255	92.57%

**Table 20: ICF-DD/N Facilities Peer Group 7 Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	51	306	111,690	100,077	89.60%
2006	46	276	100,740	96,618	95.91%
2007	58	347	126,655	117,614	92.86%
2008	56	334	121,910	112,553	92.32%

**Table 21: ICF-DD Facilities Peer Group 7 Provider Availability & Medi-Cal Utilization**

Overall Facilities			Medi-Cal Providers (Providers with at least 1 Medi-Cal Day)									Provider Participation	
Year	Total Number of Facilities	Total Licensed Beds	Medi-Cal Providers	Licensed Beds	Available Bed Days	Occupied Bed Days	Vacant Bed Days	Vacancy Rate	Medi-Cal Bed Days	Medi-Cal Occupancy Rate (of Occupied Bed Days)	Medi-Cal Occupancy Rate (of Available Bed Days)	% Facilities Participating in Medi-Cal	% of Total Licensed Beds in Medi-Cal Participating Providers
2005	2	115	2	115	41,975	40,601	1,374	3.27%	39,113	96.34%	93.18%	100.00%	100.00%
2006	2	115	2	115	41,975	39,886	2,089	4.98%	39,149	98.15%	93.27%	100.00%	100.00%
2007	2	115	2	115	41,975	40,495	1,480	3.53%	39,278	96.99%	93.57%	100.00%	100.00%
2008	1	59	1	59	21,535	21,481	54	0.25%	21,115	98.30%	98.05%	100.00%	100.00%

Peer Group Other

**Table 22: ICF-DD/H Facilities Peer Group Other Provider Availability & Medi-Cal Utilization**

Year	Number of Facilities	Total Licensed Beds	Total Available Bed Days	Total Bed Days	Occupancy Rate
2005	1	6	2,190	2,190	100.00%
2006	1	6	2,190	2,190	100.00%
2007					
2008					

There are no ICF-DD/N or ICF-DD facilities in Peer Group Other counties.

The single ICF-DD/H facility in this county closed after 2006, however there is still capacity in adjacent counties.

**Revised Reduction Proposal**

As noted above, the access analysis conducted by DHCS indicates that there have not been any significant access issues for three types of ICF-DD services, however, given some of the fluctuations in the data and the current reimbursement methodology, California did determine that a modification to the rate reduction proposal was warranted in order to help ensure continued access to these important services. As described in the rate setting section, California currently reimburses all providers at the 65<sup>th</sup> percentile of cost rate established for their particular facility type and size group. This rate methodology has resulted in some providers being paid below cost while other providers are being reimbursed significantly above cost. Given the current reimbursement structure, California determined that the payment reductions should appropriately be targeted on those facilities that were receiving payment in excess of cost. However, to account for this shift in payment methodology, we also established a three year glide path to help provide stability and a transition period for providers to adjust to the revised payment methodology.

The revised reduction proposal is based on the ultimate goal of paying providers at the lesser of the currently established 65<sup>th</sup> percentile rate for 2008-09 or their cost plus 5%. The original reduction proposal was to pay all providers at the 65<sup>th</sup> percentile for 2008-09 minus 10%. This revised proposal will provide a transition period toward the final goal by establishing a three year transition, wherein there will be limits on the percentage reduction from the 2008-09 65<sup>th</sup> percentile regardless of whether the individual provider's costs are below that rate. For June 1, 2011 through July 31, 2012, no provider will receive more than a 10% reduction from the 2008-09 65<sup>th</sup> percentile, for August 1, 2012 through July 31, 2013, no provider will receive more than a 20% reduction. Only beginning with the period starting August 1, 2013 will all providers be limited to the lesser of the 2008-09 65<sup>th</sup> percentile or their individual cost plus 5%. This revised reduction proposal will result in approximately half of the facilities receiving a reimbursement reduction, the reduction will be only on those facilities currently reimbursed above cost, and the reduction is limited to provide a transition period. Based on the analysis and the development of this revised proposal, California has determined that access to these services is not likely to be negatively impacted.

## Appendix A: Geographic Peer Group Listing

### *Peer Group 1 (Rural)*

Colusa  
Del Norte  
Imperial  
Kern  
Kings  
Lake  
Lassen  
Tulare  
Yuba

### *Peer Group 2 (Rural)*

Butte  
Humboldt  
Inyo  
Madera  
Merced  
San Luis Obispo  
Tehama  
Yolo

### *Peer Group 3 (Rural)*

Calaveras  
Glenn  
Plumas  
San Joaquin  
Shasta  
Siskiyou  
Sutter  
Ventura

### *Peer Group 4 (Rural)*

Amador  
El Dorado  
Nevada  
Placer  
Tuolumne

### *Peer Group 5 (Urban)*

Los Angeles

### *Peer Group 6 (Urban)*

Fresno  
Orange  
Riverside  
San Bernardino  
San Diego  
Santa Cruz  
Solano

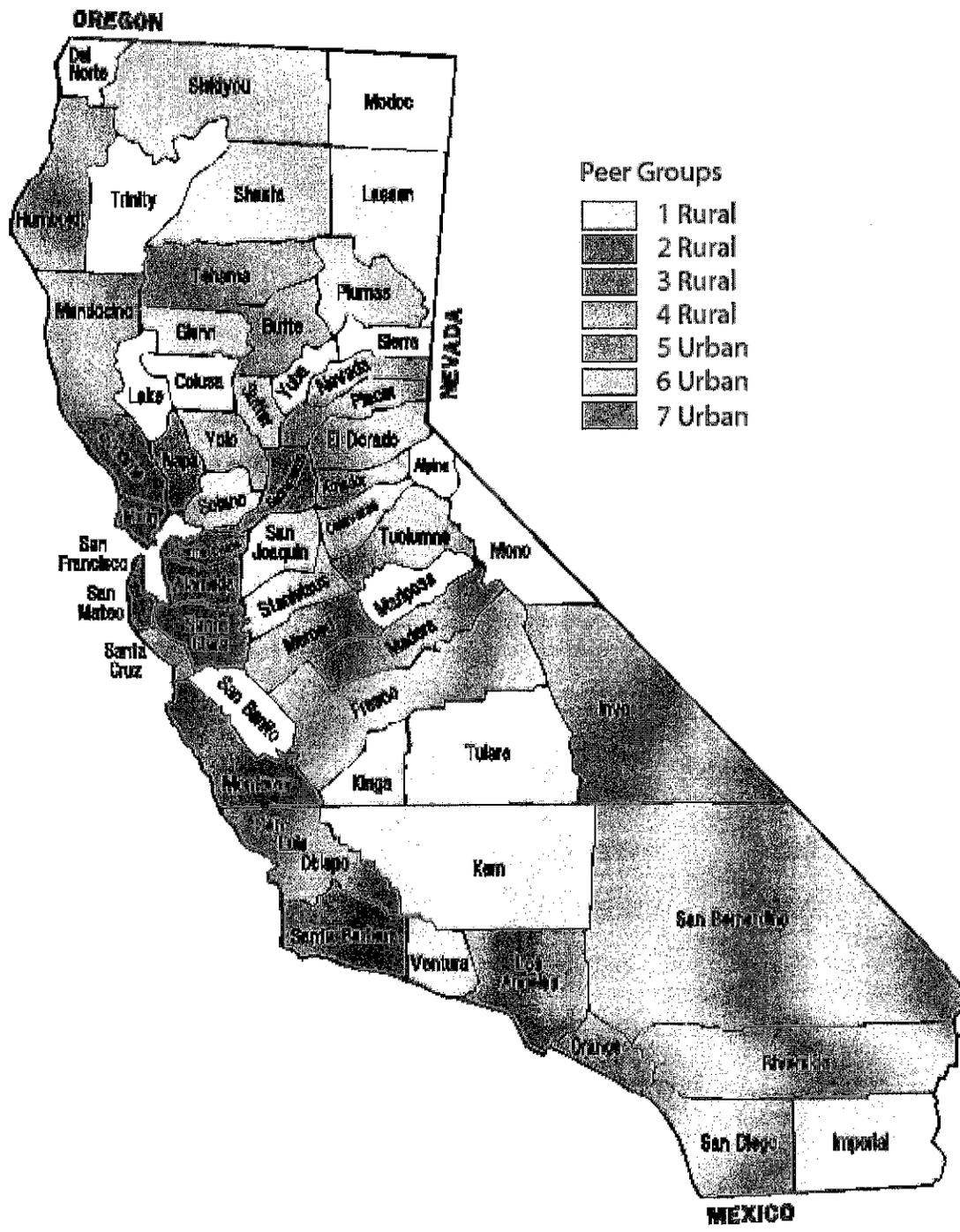
### *Peer Group 7 (Urban)*

Alameda  
Contra Costa  
Marin  
Monterey  
Napa  
Sacramento  
San Francisco  
San Mateo  
Santa Barbara  
Santa Clara  
Sonoma

### *Peer Group Other (Rural)*

Mariposa  
Modoc  
San Benito  
Trinity

# Appendix B: Map of Geographic Peer Groups



**2012-13 ICFDD, DDH, and DDN Cost Savings Rate Study  
Federal Fiscal Savings Estimates for SPA 11-010B**

Estimated 2011-12 & 2-12-13 Federal Funding Cost Savings for ICFDD, DDH, and DDN Facilities  
Proposed Rate Plus 5 Percent Compared to Current 65th Percentile Method  
Using current 2012-13 actual rates  
Based on 2012-13 RY (8/1/12-7/31/13)

		2012-13 Total Funds Cost Savings	General Fund Portion (50%) Cost Savings	Federal Fund Portion (50%) Cost Savings	Beg Month	End Month	Months of Cost Savings	2012-13 Total Funds Cost Savings	General Fund Portion (50%) Cost Savings	Federal Fund Portion (50%) Cost Savings
ICFDD	1-59	(\$524,445)	(\$262,222)	(\$262,222)	8/1/2012	7/31/2013	12	(\$12,588,273)	(\$6,294,136)	(\$6,294,136)
	60+	(\$486,098)	(\$243,049)	(\$243,049)	9/1/2012	7/31/2013	11	(\$11,539,250)	(\$5,769,625)	(\$5,769,625)
	<b>Total</b>	<b>(\$1,010,543)</b>	<b>(\$505,271)</b>	<b>(\$505,271)</b>	10/1/2012	7/31/2013	10	(\$10,490,227)	(\$5,245,114)	(\$5,245,114)
ICF DD-H	4-6	(\$6,358,198)	(\$3,179,099)	(\$3,179,099)	11/1/2012	7/31/2013	9	(\$9,441,204)	(\$4,720,602)	(\$4,720,602)
	7-15	(\$701,629)	(\$350,814)	(\$350,814)	12/1/2012	7/31/2013	8	(\$8,392,182)	(\$4,196,091)	(\$4,196,091)
	<b>Total</b>	<b>(\$7,059,827)</b>	<b>(\$3,529,913)</b>	<b>(\$3,529,913)</b>	1/1/2013	7/31/2013	7	<b>(\$7,343,159)</b>	<b>(\$3,671,579)</b>	<b>(\$3,671,579)</b>
					2/1/2013	7/31/2013	6	(\$6,294,136)	(\$3,147,068)	(\$3,147,068)
ICF DD-N	4-6	(\$4,422,851)	(\$2,211,426)	(\$2,211,426)	3/1/2013	7/31/2013	5	(\$5,245,114)	(\$2,622,557)	(\$2,622,557)
	7-15	(\$95,052)	(\$47,526)	(\$47,526)	4/1/2013	7/31/2013	4	(\$4,196,091)	(\$2,098,045)	(\$2,098,045)
	<b>Total</b>	<b>(\$4,517,903)</b>	<b>(\$2,258,952)</b>	<b>(\$2,258,952)</b>	5/1/2013	7/31/2013	3	(\$3,147,068)	(\$1,573,534)	(\$1,573,534)
					6/1/2013	7/31/2013	2	(\$2,098,045)	(\$1,049,023)	(\$1,049,023)
				7/1/2013	7/31/2013	1	(\$1,049,023)	(\$524,511)	(\$524,511)	
<b>12-13 Total Cost Savings DD, H &amp; N</b>		<b>(\$12,588,273)</b>	<b>(\$6,294,136)</b>	<b>(\$6,294,136)</b>			<b>Monthly</b>	<b>(\$1,049,023)</b>		
<b>Monthly DD, H, &amp; N (Total/12)</b>		<b>(\$1,049,023)</b>	<b>(\$524,511)</b>	<b>(\$524,511)</b>						

**Federal Cost Savings Estimates for 2011-12 and 2012-13 Rate Years**

Scenario	Start Date	End Date	Months	Total Monthly	TF Savings	GF Savings (TF/2)	FF Savings (TF/2)
Federal 11-12 RY	8/1/2012	9/30/2012	2	(\$1,049,023)	(\$2,098,045)	(\$1,049,023)	(\$1,049,023)
Federal 12-13 RY	10/1/2012	9/30/2013	12	(\$1,049,023)	(\$12,588,273)	(\$6,294,136)	(\$6,294,136)

**Assumptions:**

Using 2012-13 actual calculated rates with 12-13 Add-ons.  
DDH & DDN Add-ons include: Vaccine, FUTA, Carbon Monoxide Devices, 5010 implementation, and Elder Justice Act.  
QAF of 9.57% for 12-13 RY

Freestanding Pediatric Subacute - Comparison of 08/09 rates reduced by 5.75% w/ QAF Addon (\$2.10) to 08/09 Reduced Rate w QAF Add-on Rates

A	B	C	D	E	F	I	G
Freestanding Ped SA	CY 2010	2008/09 Unreduced Rate	2008/09 Unreduced Rate Plus Add-on(\$2.10) + QAF(\$14.42)	2008/09 Rate Reduced by 5.75%	2008/09 Reduced Rate Plus Add-on(\$2.10) + QAF (\$14.42)	Difference 08/09 unreduced Less 08/09 reduced by 5.75%	Difference 08/09 unreduced w Addon & QAF Less 08/09 reduced w Addon & QAF
		Unreduced Rate	(C+2.10+14.42)	C x (1-.0575)	(E+2.10+14.42)	(E-C)	(F-D)
Vent	42,951	\$774.53	\$791.05	\$729.99	\$746.51	(\$44.54)	(\$44.54)
Total Vent Cost (Mcal Days x rate)		\$33,266,838	\$33,976,389	\$31,353,995	\$32,063,545	(\$1,912,843)	(\$1,912,843)
Non-Vent	69,712	\$705.90	\$722.42	\$665.31	\$681.83	(\$40.59)	(\$40.59)
Total Non-Vent Cost (Mcal Days x rate)		\$49,209,701	\$50,361,343	\$46,380,143	\$47,531,785	(\$2,829,558)	(\$2,829,558)
Total Freestanding Pediatric Subacute (V + NV)	112,663	\$82,476,538.83	\$84,337,731.59	\$77,734,137.85	\$79,595,330.61	(\$4,742,401)	(\$4,742,401)
Monthly Total (Total/12)						(\$395,200)	(\$395,200)

Rate Year	Dates	Months	Monthly	Total Savings	GF	FF
Federal Rate Year 11-12	(1/1/12-9/30/12)	9	(\$395,200)	(\$3,556,800.74)	(\$1,778,400)	(\$1,778,400)
Federal Rate Year 12-13	(10/1/12-9/30/13)	12	(\$395,200)	(\$4,742,400.98)	(\$2,371,200)	(\$2,371,200)

4. Freestanding Pediatric Subacute Care Unit

Freestanding Pediatric Subacute		
Period	Reduction	With Respect to:
08/01/09 – 12/31/11	Set at Prospective rate for 2008/09	
01/01/12 - Present	5.75%	Prospective rate for 2008/09

- a. In the event that DHCS determines, pursuant to subparagraph 4.b, that reduced per-diem reimbursement rates calculated using the methodology specified in this subparagraph K.4 may be insufficient to enlist or maintain participation of providers of Freestanding Pediatric Subacute 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 Freestanding Pediatric Subacute services.
- b. The determination described in subparagraph 4.a 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 Freestanding Pediatric Subacute facilities, on a statewide basis, if the total resident occupancy on a statewide 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." The effective date for making the determination set forth in this subparagraph will be based on the effective date of SPA 11-010A (that is, January 1, 2012).
- 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. In conjunction with the reinstatement of per-diem reimbursement rates to the 2008-09 levels for the Freestanding Pediatric Subacute facilities statewide, DHCS will 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 will 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:

TN. No. 11-010A

Supersedes

TN. No. 08-009D

Approval Date \_\_\_\_\_

Effective Date January 1, 2012

- (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 paragraph 4.a will remain in effect as the reimbursement rates up to the effective date of the new SPA. The higher rates paid under paragraph 4.a will 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.
- e. The reimbursement rates resulting from the application of this Paragraph 4.a will be published on the DHCS website at the following link:  
<http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx>.
5. Pediatric Subacute Care Units that are, or are parts of, Distinct Parts of General Acute Hospitals (DP/NF Pediatric Subacute)

<b>Distinct Part Pediatric Subacute</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	

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

<b>ICF/DD</b>		
Period	Reduction	With Respect to:
08/01/09 – Present	Set at Prospective rate for 2008/09	

TN. No. 11-010A

Supersedes

TN. No. N/A

Approval Date \_\_\_\_\_

Effective Date January 1, 2012

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

<b>ICF/DD - H</b>		
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)

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

9. Rural Swing Bed

<b>Rural Swing Bed</b>		
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”.