



TOBY DOUGLAS  
Director

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



EDMUND G. BROWN JR.  
Governor

OCT 04 2011

National Institutional Reimbursement Team

Mr. Mark Cooley

CMS, CMSO

7500 Security Boulevard, M/S S3-13-15

Baltimore, MD 21244-1850

STATE PLAN AMENDMENT 11-010 and 11-010A

Dear Mr. Cooley:

The Department of Health Care Services (DHCS) is responding to the Request for Additional Information (RAI) received on September 27, 2011 for State Plan Amendment (SPA) 11-010. SPA 11-010 implements Medi-Cal payment reductions for various long term care (LTC) services to reflect the payment changes mandated as a result of Assembly Bill (AB) 97, Chapter 3, Statutes of 2011.

AB 97 authorizes DHCS to reduce Medi-Cal payments for various LTC services by an amount not to exceed ten percent of the 2008/09 rate, in the aggregate, effective for dates of service on or after June 1, 2011. Because DHCS has not finalized its decision on how what type of payment reduction it will make on all of the LTC facility types, DHCS has worked out an agreement with Centers for Medicare & Medicaid Services (CMS) staff to "split" SPA 11-010 into two separate components. Splitting the SPA 11-010 into two separate SPAs will allow CMS to approve the payment adjustments for the LTC provider types DHCS has made final decisions on and will give DHCS more time to finalize its decision on what type of payment reduction it will make on the other LTC provider types.

The LTC provider types each SPA will address are as follows:

- SPA 11-010 – DHCS had made final decisions on the type of rate adjustments it will make for each of the LTC provider lists below and amends Attachment 4.19-D pages 15.4 and 15.4a.
  - Skilled Nursing Facilities level A
  - Distinct Part Nursing Facilities (Adult)
  - Distinct Part Subacute (Adult)

- SPA 11-010A – DHCS has not finalized its decisions on what type of rate adjustment it will make on each of the LTC provider listed below and amends Attachment 4.19D pages 15.4b and 15.4c.
  - Freestanding Pediatric Subacute
  - Distinct Part Pediatric Subacute
  - Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
  - ICF/DD – Habilitative
  - ICF/DD – Nursing
  - Rural Swing Beds

Enclosed you will find SPA pages for each of the SPA noted above and:

- Response to the RAI dated September 27, 2011.
- HCFA 179 form.
- SPA Impact form

If you have any further questions regarding the responses or the SPA, please contact Ms. Vickie Orlich, Chief, Medi-Cal Benefits, Waiver Analysis, and Rates Division, at (916) 552-9400.

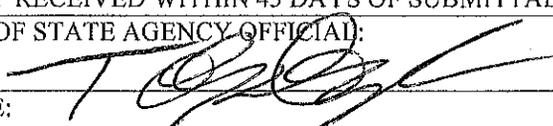
Sincerely,



Toby Douglas  
Director  
Department of Health Care Service

Enclosures

cc: Vickie Orlich, Chief  
Medi-Cal Benefits, Waiver Analysis and Rates Division  
1501 Capitol Avenue, MS 4600  
Sacramento, CA 95814

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>11-010A</b>	2. STATE <b>California</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		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 <b>June 1, 2011</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>AB 97</b>		7. FEDERAL BUDGET IMPACT: a. FFY <b>2010-2011</b> \$ b. FFY <b>2011-2012</b> \$	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-D Page 15.4b and 15.4c</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): <b>Attachment 4.19-D Page 15. 4b and 15.4c</b>	
10. SUBJECT OF AMENDMENT: <b>Reduced payment rates as mandated by Assembly Bill 97</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor's Office does not wish to review State Plan Amendments <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Avenue, Suite 71.4001 P.O. Box 997417 Sacramento, CA 95899-7417</b>	
13. TYPED NAME: <b>Toby Douglas</b>			
14. TITLE: <b>Director</b>			
15. DATE SUBMITTED: <b>10/4/11</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

2. A skilled nursing facility that is a distinct part of a general acute care hospital as defined in Section 72041 of Title 22 of the California Code of Regulations.
3. A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.

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

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

<b>Nursing Facilities Level A</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 - 05/31/11	5%	Prospective rate for 2008/09
06/01/11 - Present	10%	Prospective rate for 2008/09

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

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

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

<b>Distinct Part Adult 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	

TN. No. 11-010

Supersedes

TN. No. 08-009D

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

Effective Date June 1, 2011

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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: Yes.

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

DHCS's Response: Please refer to the revised HCFA Form 179. CMS has permission to make pen-and-ink changes to HCFA 179 as necessary. The fiscal estimates on the payment reductions was calculated for each federal fiscal year (FFY) based on the types and services that were reduced in that particular FFY, the percentage reduction for that particular FFY, and the effective dates of the reductions.

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, 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.”

- 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 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.”

- 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 the Department's Monitoring Access to Medi-Cal Covered Healthcare Services report.

- 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's Response: The State held legislative hearings for Assembly Bill 97 (Chapter 3, Statute 2011) and published notices to engage providers, advocates and beneficiaries. The State was able to learn of their concerns and considered them in the legislative hearing process. Providers were concerned with losing revenue and their ability to continue to provide access to care.

- 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: No, the State is not modifying anything else in the State Plan other than what has been specifically mentioned.

- 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 the Department's "Monitoring Access to Medi-Cal Covered Healthcare Services" report. Further, DHCS developed a comprehensive access monitoring plan that was incorporated in SPA 08-

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009B1 as Attachment 4.19-F, entitled "Measuring Access to Medi-Cal Covered Healthcare Services."

- 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 the Department's "Monitoring Access to Medi-Cal Covered Healthcare Services" report. Further, DHCS developed a 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."

- 4. CMS has received numerous requests from various long term care providers, particularly from ICF/DD providers and distinct part providers, to 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: AB 97 (2011) authorized the Department to vary the application of the 10 percent payment reductions among provider types, so long as, in the aggregate, the reductions totaled no more than 10 percent. No final determination has been reached regarding the reductions for Rural Swing Bed, ICF/DD (including Habilitative and Nursing), or Pediatric DP and FS Subacute facilities at this time. Therefore these issues will be addressed in SPA 11-010(A). The State has decided not to reduce reimbursement rates for Distinct Part Subacute providers any further.

- 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: No litigation has been filed to date for the 10 percent reductions that took effect on June 1, 2011.

- 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?**

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DHCS's Response: Please see response for Question Number 5 regarding litigation. There is a court ordered injunction March 3, 2011. The Department will comply with any injunction according to its provisions. It is the Department's intent to implement a 10% reduction in reimbursement rates to NF-A and DP/NF-B. The Department will address the following items in SPA 11-010(A): Rural Swing Bed, ICF/DD (including Habilitative and Nursing), or Pediatric DP and FS Subacute facilities

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 State has revised SPA pages 15.4 and 15.4a to combine SPAs 08-009D, 09-019, and 10-021.

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: SPA 11-010(A) will address this issue at a later date.

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: SPA 11-010(A) will address this issue at a later date.

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: SPA 11-010(A) will address this issue at a later date.

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 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: SPA 11-010(A) will address this issue at a later date.

The following 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 receive 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.)**

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**

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**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; and,
- (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 2007-08. It is our understanding that the overall payment amount does not change significantly from one year to another.

<b>Facility Name</b>	<b>Operational Nature</b>	<b>FFP (CPE based)</b>	<b>Taxing Authority</b>	<b>Received State Appropriations</b>
Alameda County Medical Center D/P SNF	County	\$2,449,692.78	County has taxing authority	no
Bear Valley Community Hospital D/P SNF	Health Care District	\$-	Health Care District has taxing authority	-
Catalina Island Medical Center D/P SNF	Non-Profit**	\$28,787.01	City has taxing authority	no
Edgemoor Geriatric Hospital	County	\$1,695,923.85	County has taxing authority	no
Hazel Hawkins Memorial Hospital	Health Care District	\$79,375.44	Health Care District has taxing authority	no
Kaweah Delta District Hospital D/P SNF	Health Care District	\$-	Health Care District has taxing authority	-

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Laguna Honda Hospital & Rehabilitation CTR D/P SNF	County	\$3,007,317.78	County has taxing authority	no
Mountains Community Hospital D/P SNF	Health Care District	\$-	Health Care District has taxing authority	-
San Francisco General Hospital D/P SNF	County	\$2,274,290.64	County has taxing authority	no
San Mateo (Crystal Springs) Medical Center D/P SNF	County	\$3,272,363.73	County has taxing authority	no
Sonoma Valley Hospital D/P SNF	Health Care District	\$51,142.57	Health Care District has taxing authority	no
Tahoe Forest Hospital D/P SNF	Health Care District	\$162,105.93	Health Care District has taxing authority	no

\* Figures were taken from claim schedules, provided by accounting, for DOP period FY 07/08

\*\* Owned by the City of Avalo

**Note:** N/A = Facilities did not claim or receive payments for the period referenced

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.

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- 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-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 2007-2008 FFP estimate is \$13,021,000.

- 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 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 exceeded their reasonable costs of providing services.