



TOBY DOUGLAS  
Director

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



EDMUND G. BROWN JR.  
Governor

MAR 09 2012

National Institutional Reimbursement Team  
Mr. Mark Cooley  
Centers for Medicare and Medicaid Services  
Centers for Medicaid and State Operations  
7500 Security Boulevard, M/S S3-13-15  
Baltimore, MD 21244-1850

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

Dear Mr. Cooley:

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

SPA 11-010A will amend Attachment 4.19-D, page 15.4b, to implement a Medi-Cal payment reduction of 5.75 percent for Freestanding Pediatric Subacute Facilities authorized by State law enacted under ABx1 9 (Statutes of 2011). DHCS is requesting that SPA 11-010A be placed "back on the clock" as it was previously submitted.

SPA 11-010B will amend Attachment 4.19-D by adding pages 15.4c.1 and 15.4c.2, and reduce Medi-Cal payments in accordance with California Assembly Bill (AB) 97 (Statutes of 2011), which authorizes DHCS to reduce payments for long term care (LTC) provider types by an amount not to exceed ten percent of the 2008-09 rate, effective for dates of service on or after June 1, 2011. SPA 11-010B has been amended to reflect DHCS' final decision as to how to implement the payment reductions under AB 97. Specifically, SPA 11-010B proposes various revisions to the rate-setting methodology for Intermediate Care Facilities for the Developmentally Disabled, including Habilitative and Nursing, whereby most facilities will receive a rate reduction but will still receive reimbursement in excess of their projected costs. In addition, no facility will receive more than a ten percent rate reduction beginning January 1, 2012.

Enclosed you will find the following:

- SPA pages for each of the SPAs noted above.
- Responses to the RAI dated September 27, 2011.

- Responses to concerns raised by the Developmental Services Network (DSN) in a November 15, 2011, letter, and December 14, 2011, e-mail. Enclosed for your quick reference are DSN's letter and e-mail.

If you have any further questions regarding the SPAs or the request for additional information responses, please contact Mr. Tim Matsumoto, Acting Chief, Fee-For-Service Rates Development Division, at (916) 552-9639.

Sincerely,



Toby Douglas  
Director

Enclosures

cc: Tim Matsumoto, Acting Chief  
Fee-For-Service Rates Development Division  
1501 Capitol Avenue, MS 4600  
Sacramento, CA 95814



TOBY DOUGLAS  
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Ms. Gloria Nagle, Ph.D., MPA  
Associate Regional Administrator  
National Reimbursement Team  
Centers for Medicare and Medicaid Services  
Division of Medicaid and Children's Health  
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San Francisco, CA 94103-6707

Ms. Nagle:

This provides responses to the November 15, 2011, letter the Centers for Medicare and Medicaid Services (CMS) received from the Developmental Services Network (DSN) in which they express concerns regarding the Department of Health Care Services' (DHCS) proposal for modifying the existing Medi-Cal reimbursement rate-setting methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative and ICF/DD-Nursing, hereafter referred to as ICF/DDs, unless otherwise specified.

This letter also provides a response to the December 14, 2011, e-mail CMS forwarded to the DHCS in which DSN questioned how the state is able to claim there is no access issues in regard to ICF-MR services, yet are spending state and federal money to develop additional inventory by opening a new ICF-MR facilities. DSN raised this question in response to a Request For Proposals (RFP) recently published by Regional Centers.

As CMS is aware, the current ICF/DD rate-setting methodology has resulted in some facilities that are reimbursed below "audit adjusted cost" (cost) while a significant number of facilities are being reimbursed above cost. Given the current reimbursement structure and current budget constraints, it is imperative that DHCS consider a methodology that more appropriately reimburses facilities.

In the opening paragraph of DSN's November 15, 2011 letter, they state that DHCS advised DSN that they submitted a new State Plan Amendment (SPA) requesting to reduce the 2008 rate levels for the ICF/DDs to the lesser of cost plus 5 percent or the 65<sup>th</sup> percentile. DSN has not seen the most recent DHCS proposal that proposes to use updated projected cost information for the cost plus 5 percent component of the rate methodology. DHCS submitted our revised proposal to CMS via email on

November 23, 2011. DHCS believes that this latest approach should alleviate several of the concerns raised by DSN in their November 15, 2011 letter.

After carefully reviewing the comments and concerns DSN provides in its letter, we wanted to provide CMS with the following information:

ICF Facility Rates Have Already Been Reduced by 6.4-9.03%

DSN states that rates should have been increased based on the rate study for August 1, 2009, and expressed concerns regarding recently approved SPAs. Although the DHCS did conduct an annual rate study for the 2009-2010 rate year, DSN is aware Health Trailer Bill ABx4 5 (Statutes 2009) required DHCS to freeze the 2009-2010 rates at the rates established in 2008. DSN is also aware that one of the six ICF/DD-N 2008-2009 peer group rate calculations resulted in a 65<sup>th</sup> percentile rate lower than the previous rate year's rate; therefore, instead of lowering the 2008-2009 65<sup>th</sup> percentile rate to reflect the true projected costs, DHCS held that rate harmless. Thus, the 2009-2010 rate paid for this peer was frozen at the higher rate. Until such time CMS approves DHCS' proposed ICF/DD reimbursement methodology under State Plan Amendment 11-010B, effective January 1, 2012, DHCS will continue to pay the providers in that peer group a 65<sup>th</sup> percentile hold-harmless rate.

The New Proposal Would Cut Rates by Almost 70% for Some Providers

As you are aware, DHCS' revised proposal would not result in any provider receiving more than a 10% reduction from current reimbursement levels in FY2011-12. In addition, DSN requested that DHCS provide the facility specific data on the impact of the most recent proposal. DHCS is currently calculating that cost and will provide to DSN and CMS upon completion.

Hundreds of Facilities Will Close

In their letter, DSN states that there will not be adequate funding to enable providers to provide basic services, which could impede provider compliance with state and federal mandated rate components. DHCS does not concur with this statement, since the current rate-setting proposal will result in a facility either receiving reimbursement in excess of their projected allowable costs or their current reimbursement rate at the 2008-09 65<sup>th</sup> percentile level recently approved by CMS in October 2011. DHCS further believes that the current proposal minimizes the impact of the payment reductions under the 2011 Health and Welfare Budget Trailer Bill, Assembly Bill 97, which proposed across-the-board payment reductions of ten percent. By modifying the proposed reimbursement methodology to take into consideration an individual facility's projected cost, DHCS believes that facilities will be more appropriately reimbursed and will result in a majority of facilities from receiving any reimbursement reduction. Only those facilities that, under the current reimbursement structure, receive a rate that is more than five-percent above cost will receive a reimbursement reduction.

The State's "Access Study" Fails to Demonstrate Access Will Not Be Impaired

DSN raises the issue of the range of the vacancy rates in ICF/DDs which they state often result in access issues in locating appropriate placements. DHCS's proposal will

not adversely impact access, given that all facilities will be paid their current rate at the 65th percentile or an amount above their projected costs. DHCS believes that it is helping to protect access by ensuring reimbursement rate reductions are only applied to those facilities currently receiving reimbursement in significant excess of their projected costs.

The State's New Rate Setting Methodology is Flawed

In their letter, DSN makes three assertions regarding the cost data to be used by DHCS in setting the rates:

- 1) Base costs are not current;
- 2) The audit process results in audit adjustments that are inequitable; and
- 3) California Consumer Price Index (CCPI) suggests facility costs will increase.

We will address each of the three assertions below.

- 1) As mentioned above, DSN has not seen the most recent DHCS proposal that proposes to use updated projected cost information for the cost plus 5 percent component of the rate methodology. DHCS submitted our revised proposal to CMS via email on November 23, 2011. DHCS believes that this latest approach should alleviate this concern raised by DSN in their November 15, 2011 letter.
- 2) DSN states in its letter that the methodology is further flawed as it relies on aggregate audit data to determine facility specific costs, and that the audit process results in audit adjustments that are inequitable. As CMS is also aware, an audit adjustment factor is applied to the cost reports for the ICF/DDs – Habilitative and ICF/DDs – Nursing, since the total number of these facilities is too large to audit all of the facilities. Accordingly, a statistically valid random sample of these facilities is audited each year, and an individual audit adjustment factor is calculated for each of the two facility types. For example, the audit adjustment factor to be applied to the ICF/DD-Habilitative reported costs is determined by using only the Habilitative facility data in the random sample. In the aggregate, facilities that do report their costs accurately will cause an impact on the projected costs. Historically since 2000, the audit adjustment factors applied to the ICF/DD-Habilitative and Nursing reported costs have varied from 91 percent to 96 percent, averaging approximately 94.7 percent. Because the pure, non-state-owned or operated, ICF/DD population consists of only 10 facilities, DHCS receives audits of the providers' reported costs; therefore, an audit adjustment is not necessary. Given the results of these audit adjustments, DHCS proposed methodology has provided for a "cushion" of 5 percent in part to help mitigate this concern.
- 3) In annual reviews of CCPI projections, DHCS has found that in the aggregate the CCPI consistently reflects increases. The existing reimbursement methodology, as well as in the proposed reimbursement methodology, incorporates these increases in the update of providers' reported costs. Thus, these increases are accounted for in projected costs used to determine the ICF/DD reimbursement rates.

#### The Proposal Will Result in Increased Costs

In their letter, DSN states that ICF/DDs are operating near maximum capacity, and informs CMS that closures will result in current ICF consumers being placed in state developmental centers at a cost much higher than the costs of placement in a community home. As CMS knows, since the revised DHCS proposal will result in a facility receiving the lower of its own projected cost plus 5 percent or the current reimbursement rate at the 2008-09 65<sup>th</sup> percentile, and includes phase in for those whose projected costs plus 5 percent are less than the 2008-09 rate, DHCS believes that it is helping to protect access by ensuring reimbursement rate reductions are only applied to those facilities currently receiving reimbursement in significant excess of their projected costs.

#### Proposed SPA Raises Issues in Respect to the Olmstead Decision

DSN's letter includes significant concerns that many of the current residents in ICF homes have come from state developmental centers as a result of the Olmstead decision which requires placement out of state institutions into ICF DDH and DDN homes. DSN further states that providers will be unable to accommodate this further demand for services within existing resources. While DHCS appreciates DSN's concerns, DHCS does not believe our proposed State Plan will preclude new providers from opening a new ICF DDH and DDN homes for placement, since new providers will receive the reimbursement rate per patient day set at the median of projected costs for their peer group until such time the department receives cost data.

#### The Retroactive Application of the Rate Cuts Cause Additional Facility Closures Alone

DSN states in their letter that the retroactive component of the payment reduction in which DHCS intends to recover overpayments made to providers retroactive to June 1, 2011, is "very unwise" because the payments providers earned have already been spent. DHCS understands that it may be difficult for some providers to pay back overpayments they continue to receive, retroactive to June 1, 2011, as a result of the additional time it has taken to proceed with these payment reductions. DHCS has revised its proposal to limit the retroactivity of the revised reimbursement proposal to January 1, 2012. In addition, the state has developed a mechanism for the more limited retroactive application under which the State does not intend to (1) collect immediately, and (2) collect in a lump sum. Instead, the State intends to begin collecting once the payment reductions are implemented. At such time, DHCS plans to further reduce payments by an additional 5 percent until the state is reimbursed the entire retro portion due. DHCS believes that this would soften the impact of provider repayments that might otherwise be devastating to providers.

#### DSN's December 14, 2011, E-mail Regarding Request for Proposals

In DSN's e-mail to CMS, they questions how the State can claim there are no access issues in ICF/DDs yet are spending state and federal money to develop new inventory.

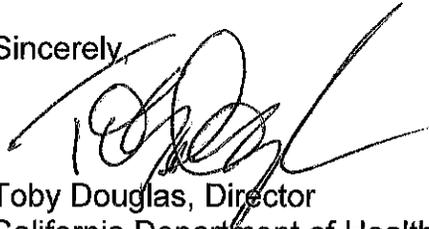
Attached to DSN's e-mail was a Request For Proposal (RFP) published by Alta California Regional Center (ACRC) on December 12, 2011. The RFP states the need to open four (4) residential facilities within the Alpine, Colusa, El Dorado, Nevada,

Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba Counties, and specifically requests an ICF/DD-Habilitative facility with up to six (6) beds.

ACRC's efforts to increase access in certain areas are not inconsistent with DHCS' analysis that sufficient access exists, but simply indicates a desire to further promote access.

We thank you for consideration of our comments. If you have any questions, please contact Mr. Tim Matsumoto, Acting Chief, Fee-For-Service Rates Development Division, at (916) 552-9639, or at [Tim.Matsumoto@dhcs.ca.gov](mailto:Tim.Matsumoto@dhcs.ca.gov).

Sincerely,



Toby Douglas, Director  
California Department of Health Care Services

cc: Mr. Mark Wong  
National Reimbursement Team  
Centers for Medicare and Medicaid Services  
Division of Medicaid and Children's Health  
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SPA 11-010 Request for Additional Information (RAI) Questions from CMS and  
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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 2010-2011 (\$ N/A – ICF/DDs) (\$827,031 – FS Ped Subs)
- b. FFY 2011-2012 (\$ 3,409,531 – ICF/DDs) (\$2,481,094 – 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 June 1, 2011,

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through September 30, 2011, for FFY 2010-2011, and October 1, 2011, through July 31, 2012, for FFY 2011-2012.

- 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."

In addition, please refer to the Medi-Cal Fee-For-Service Long-Term Care Access Analysis: Intermediate Care Facilities for the Developmentally Disabled previously forwarded to CMS on November 3, 2011.

- 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.

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- 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: 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 hearing process. Providers were concerned with losing revenue and their ability to continue to provide access to care. DHCS modified the initial reduction proposal in acknowledgement that an across-the-board 10 percent reduction to these types of facilities may have had an impact on access. This revised proposal ensures access by ensuring that the facilities will either receive reimbursement at 5 percent above projected costs or at the current 2008-09 65<sup>th</sup> percentile.

- 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?**

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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 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 below:

- ICF/DD, ICF/DD-H, and ICF/DD-N: The revised methodology proposal takes into consideration the providers' updated reported costs plus 5 percent, which is excess of their actual reported costs, or will reimburse those providers the 65<sup>th</sup> percentile rate that had reported costs above the 65<sup>th</sup> percentile rate.
- 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: Nursing Facilities Part B (NF-B) – Skilled Nursing and Sub-Acute Services (attached).
- Distinct Part Pediatric Subacute: No reduction.

- 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: A lawsuit was filed by the California Hospital Association in federal court challenging the 10 percent reduction for DP/NF-B providers. On

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December 28, 2011, the federal court issued a preliminary injunction. The Department is complying with the injunction according to its provisions.

- 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, an injunction has been issued and DHCS is complying with the injunction according to its provisions. However, the injunction 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)
- 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)

- 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 by combining SPAs 09-019, and 10-021 with SPA 08-009D, which was subsequently approved by CMS on October 27, 2011.

**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.**

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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 exemption with regard to 4.19 D. The State will maintain the same payment methodology approved in Section K.9 of SPA 08-009D (page 15c).

The State has removed rural swing bed from the previously submitted SPA 11-010B, to reflect that the State's desire to continue the payment methodology approved in Section K.9 of SPA 08-009D (page 15c).

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: We have clarified this through SPA 11-010A, Attachment 4.19-D, Page 15.4b, that specifies the provider types to which the reductions apply.

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: 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

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affect DHCS' level of reimbursement. As a result of the additional funds received, instead of reducing provider payments by 10 percent, DHCS will only 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, 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 for the FS Pediatric Subacute facilities.

**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.)**

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**

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**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 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	None	Health Care District has taxing authority	N/A
Catalina Island Medical Center D/P SNF	Non-Profit**	\$28,787.01	City has taxing authority	no

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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	None	Health Care District has taxing authority	N/A
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	None	Health Care District has taxing authority	N/A
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	Health Care	\$162,105.93	Health Care District has	no

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D/P SNF	District		taxing authority
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\* Figures were taken from claim schedules, provided by accounting, for DOP period FY 07/08

\*\* Owned by the City of Avalon

**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.

- 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 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**

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**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.

4. Freestanding Pediatric Subacute Care Unit

<b>Freestanding Pediatric Subacute</b>		
Period	Reduction	With Respect to:
08/01/09 - 05/31/11	Set at Prospective rate for 2008/09	
06/01/11 - Present	5.75%	Prospective rate for 2008/09

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

<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	

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".