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

Center for Medicaid, CHIP, and Survey & Certification

APR 1 5 2011

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

RE: California State Plan Amendment TN: 08-010

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 08-010. This State Plan Amendment (SPA), effective August 1, 2008, provides for an extension of the expiration date of the rate methodology for freestanding skilled nursing facilities and subacute care units of freestanding skilled nursing facilities; the facility-specific rate methodology now remains in effect until July 31, 2011.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 08-010 is approved effective August 1, 2008. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

Bill Lawson
for Cindy Mann
Director, CMCS

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 08-010

2. STATE: CA

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

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

4. PROPOSED EFFECTIVE DATE: August 1, 2008

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

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

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

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

7. FEDERAL BUDGET IMPACT:
a. FFY N/A $
b. FFY $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 4 to Attachment 4.19-D, pgs 1,10, 14 ~~and~~ 16 , and 17

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 4 to Attachment 4.19-D pgs 1, 10 14 ~~and~~ 16 , and 17

10. SUBJECT OF AMENDMENT:
Extend the operative date for the facility-specific rate methodology of AB 1629 of 2004 from July 31, 2008 to July 31, 2011.

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:
Stan Rosenstein

13. TYPED NAME:
Chief Deputy Director, Health Care Programs

14. TITLE:

15. DATE SUBMITTED: 9/30/08

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 04-15-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG - 1 2008

20. SIGNATURE OF REGIONAL OFFICIAL: Bill Lasowski, R CN

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

Pen-and-ink changes made by Regional Office to Boxes 6, 8, and 9, with State concurrence.

FORM HCFA-179 (07-92)

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

I. Introduction

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

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

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

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

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

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

years subtracted from their facility age to compensate for any improvements, renovations or modifications that have occurred in the past. The age of each facility will be adjusted every rate year to make the facility one year older, up to a maximum age of 34 years.

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

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

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

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

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

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

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

ii. For the 2006/07, 2007/08, 2008/09, 2009/10 and 20010/11 rate years, the maximum annual increase for the capital cost category for all FS/NF-Bs in the aggregate will not exceed eight percent of the prior rate year's FRVS aggregate payment.

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

iv. If the capital cost category for all FS/NF-Bs in the aggregate for the 2006/07, 2007/08, 2008/09, 2009/10 and 20010/11 rate years exceeds eight percent of the prior rate year's cost category, the Department will reduce the capital FRVS cost category for each and every FS/NF-B in equal proportion.

5. Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, the Medi-Cal portion of the skilled nursing facility quality assurance fee, and new state and federal mandates for the applicable rate year.

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

b. Caregiver training costs are defined as a formal program of education that is organized to train students to enter a caregiver occupational specialty. Until the Medi-Cal cost report is revised to specifically identify these costs, FS/NF-Bs will be required to complete an annual supplemental report detailing these

G. The percentiles in labor costs, indirect care non-labor costs, and administrative costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis.

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

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

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

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

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

D. For the 2009/10 and 2010/11 rate years, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5 percent of the weighted average Medi-Cal rate for the prior fiscal year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

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

VII. Peer-Grouping

The percentile caps for FS/NF-B facility labor, indirect care non-labor, and administrative costs will be computed on a geographic peer-grouped basis.

The median per diem direct resident care labor cost for each individual county will be subjected to a statistical clustering algorithm, based on commercially available statistical software. The statistical analysis of county costs will result in a defined and finite number of peer groups. A list of counties and their respective peer groups, along with a more detailed explanation of the peer-grouping methodology is available on-line at: http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx, or by contacting the Department at:

California Department of Health Services
Medi-Cal Policy Division/Long-Care System Development Unit
MS 4612
P.O. Box 997417
Sacramento, CA 95899-7417

Phone: (916) 552-9600

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

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

B. New FS/NF-Bs with no cost history in a newly constructed facility or an existing facility newly certified to participate in the Medi-Cal program will receive an interim reimbursement rate based on the peer-grouped weighted average Medi-Cal reimbursement rate. Once the FS/NF-B has submitted six months of cost and/or supplemental data, its facility-specific rate will be calculated according to the methodology set forth in this Supplement. The difference between the FS/NF-B's interim per diem payment rate and the facility-specific per diem payment rate calculated based on Section V of this Supplement will be determined upon audit or review of the cost report and/or supplemental report. The Department will adjust the difference in reimbursement rate on a prospective basis, consistent with the methodology described in Section IV.C.2 of this Supplement.

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