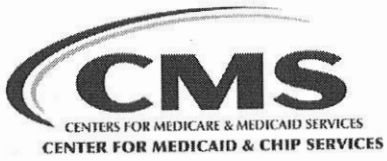
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850




**Financial Management Group**

MAR 22 2017

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: California State Plan Amendment 16-037

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 16-037. This State plan amendment (SPA) updates Attachment 4.19-D to authorize the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) System for the rate year beginning August 1, 2016 and adds Activities of Daily Living and Direct Care Staff Retention quality measures.

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. This is to inform you that Medicaid State plan amendment TN 16-037 is approved effective August 1, 2016. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Blake Holt at (415) 744-3754.

Sincerely,

ORIGINAL SIGNED

Kristin Fan
Director

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: 16-037

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, 2016

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:
CCR Title 22, Section 51124.5

7. FEDERAL BUDGET IMPACT:
a. FFY 2015/16 $ 7,500,000
a. FFY 2016/17 $ 37,500,000 ~~$ 45,000,000~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 4 to Attachment 4.19-D pages 20, 20b, 21, 22, 23, 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 4 to Attachment 4.19-D pages 20, ~~20b,~~ 21, 22, 23, 24

10. SUBJECT OF AMENDMENT:
Extends the Quality and Accountability Supplemental Payment program from through July 31, ~~2020,~~ 2017 adds activities of daily living and direct care staff retention quality measures.

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.

ORIGINAL SIGNED

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED: SEP 29 2016

16. RETURN TO:

**Department of Health Care Services**
**Attn: State Plan Coordinator**
**1501 Capitol Avenue, Suite 71.326**
**P.O. Box 997417**
**Sacramento, CA 95899-7417**

## IX. Quality and Accountability Supplemental Payment

A. For the rate year beginning August 1, 2016, the Department will develop and implement the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) System. This program provides supplemental reimbursement for FS/NF-Bs, including FS/adult subacute facilities, that improve the quality of care rendered to its residents and would be in addition to the rate of payment FS/NF-Bs receive under the current reimbursement methodology.

B. The Department, in consultation with California Department of Public Health (CDPH) and representatives from the long-term care industry, organized labor, and consumers; has developed a three tiered scoring methodology, with improvement scoring, for supplemental payments. The Minimum Data Set data file is obtained from the Centers for Medicare & Medicaid Services (CMS). The Department has a data use agreement with the Health Services Advisory Group for such purposes.

1. 100 points are divided among the measurements with point values distributed for each quality indicator.

| Measurement Area/Indicator | Possible Points: |
|---|---|
| Minimum Data Set Clinical | 100.00 |
| Influenza Vaccination: Short Stay | 6.25 |
| Pneumococcal Vaccination: Short Stay | 6.25 |
| Facility Acquired Pressure Ulcer Incidence | 12.50 |
| Urinary Tract Infection | 12.50 |
| The Use of Physical Restraints | 12.50 |
| Control of Bowel or Bladder | 12.50 |
| Self-Reported Pain: Short Stay | 6.25 |
| Self-Reported Pain: Long Stay | 6.25 |
| Activities of Daily Living: Long Stay | 12.50 |
| Direct Care Staff Retention | 12.50 |

2. A facility's score for each indicator is as follows: a facility's performance is less than statewide average: zero points; at or above statewide average, up to but not including 75th percentile: half points; at or above the 75th percentile: full points. Indicators may be added or removed in the future, subject to state and CMS approval.

   In determining the statewide average and the 75th percentile for each indicator, the performance of all facilities, including ineligible facilities as defined in paragraph C below, are included.

3. Facilities receive an overall quality of care score when points from each of the quality measures are totaled.

4. Facilities that score at least 50.00 points are eligible for QASP payments.

5. For the clinical quality measures, the prior state fiscal year (July 1 to June 30) performance is used for current rate year payment as well as determination of the 75th percentile and statewide average, except for the staff retention measure. For example, MDS data from the performance period of July 1, 2013 to June 30, 2014 will be used to make rate year 2014/15 payments.

   For the clinical quality measures, CDPII, in collaboration with the Department, computes each facility's score based on the MDS data. In using the MDS data file, the Long Stay Pressure Ulcer measure is adjusted so that unhealed pressure ulcers are not added back into the performance calculation.

   For the direct care staff retention measure, cost reports available from the Office of Statewide Health Planning and Development (OSHPD) for the audit period will be used. The measure will rank facilities based on the amount of direct nursing staff turnover during the reporting period, calculated by dividing "Number of Continuously Employed Direct Nursing Staff During the Report Period" by "Number of Direct Nursing Staff at the Beginning of the Report Period," with less turnover scoring higher.

6. Eligible facilities are grouped into three payment tiers based on their overall quality of care score. Facilities with scores from 0 to 49.99 points are grouped as Tier 1. Facilities with scores from 50.00 to 66.66 points are grouped into Tier 2. And facilities with scores from 66.67 to 100 points are grouped into Tier 3. Ineligible facilities, as defined in paragraph C, are grouped into Tier 0.

   Tier 0 and Tier 1 facilities will not receive any supplemental payments under this QASP program component. The total pool amount for this component is converted into a Tier 2 per diem and a Tier 3 per diem. The Tier 3 per diem is set at 1.5 times the Tier 2 per diem. Each facility within Tier 2 and Tier 3 will receive a supplemental payment equal to the respective tier per diem times the facility's number of Medi-Cal bed days (including Fee-For-Service and managed care days) for the audit period.

The formula for determining the Tier 2 and Tier 3 per diems is as follows:

Total pool = (Aggregate Tier 2 Medi-Cal bed days* x Tier 2 per diem) + (Aggregate Tier 3 Medi-Cal bed days* x 1.5 x Tier 2 per diem)

Tier 3 per diem = Tier 2 per diem x 1.5

* Medi-Cal bed days total for the audit period includes Fee-For-Service and managed care days

The Department will utilize managed care and audited Medi-Cal Fee-For-Service and managed care bed days for determining payment amounts. The audited bed days are drawn from the audit reports used to establish 2016/17 Fee-For-Service per diem rates. Note that any facility that does not have any Medi-Cal Fee-For-Service days from audit period would not be included in the above computation and will not receive this payment.

Below is an example of a three tiered payment methodology:

**Total Payout $90M**

| Payment Tier | Point Range | # of SNFs | Payout per MCBD | Total MCBDs per Tier | Total Payout per Tier | Ave Payout per SNF |
|---|---|---|---|---|---|---|
| Tier 0 | | 346 | $0.00 | 5,811,700 | $0 | $0 |
| Tier 1 | 0 – 49.99 | 419 | $0.00 | 10,280,958 | $0 | $0 |
| Tier 2 | 50.00 – 66.66 | 211 | $12.15 | 4,381,696 | $53,237,607 | $252,310 |
| Tier 3 | 66.67-100 | 119 | $18.23 | 2,019,628 | $36,807,720 | $309,307 |
| Total Receiving Payment | | **330**<br>**30.14%** | | | | **$272,865** |

7. An additional component of the QASP program is the improvement scoring, where 10% of the payment allocation is set aside for facility improvements from the baseline year.

   A facility's overall quality of care score as determined in paragraph B during a performance period is compared to the facility's score from the immediate prior performance period (base period). For example, for rate year 14/15 payment purposes, the facility's score for its performance in the 13/14 period is compared to its score for performance in the 12/13 base period. The difference is the improvement score. The improvement score for all facilities are ranked. Tier 0 facilities in the performance period are not included in the ranking as they are ineligible and not assigned a score. Additionally, a Tier 1/2/3 facility in the performance period would not be included in the Improvement ranking if the facility: 1) did not have any Medi-Cal bed days in the base period; 2) did not have any MDS clinical measure data in the base period; or 3) is a new facility in the performance period. Facilities in the top 20th percentile in the improvement score ranking will receive a supplemental payment under the improvement component.

   The total improvement pool amount specified in paragraph B.8 below is divided by the total number of Medi-Cal bed days (including both Fee-For-Service and managed care days) for all facilities qualifying for an improvement component payment. The result is an improvement per diem. Each facility qualifying for an improvement component supplement payment

will receive a supplement payment equal to the improvement per diem times its number of Medi-Cal days (including Fee-For-Service and managed care).

The Medi-Cal days are derived from the same source as Medi-Cal days in paragraph B.6.

Note that any facility that does not have any Medi-Cal Fee-For-Service days in the audit period would not be included in the above computation and will not receive this payment.

8. The aggregate supplemental payments will be funded by a pool of $90,000,000 for the 2016/17 rate year. $79,200,000 will be the total pool amount used to compute the Tier 2 and 3 per diems in paragraph B.6, and $8,800,000 will be the total pool amount used to compute the improvement per diem in paragraph B.7. $2,000,000 total funds will be the total pool amount used to fund delayed QASP payments which are made after the primary payment, but before June 30, 2018. An example of a delayed payment would be where a facility was originally determined to be ineligible in accordance with paragraph C.a, at the time of primary payment, but such determination was later successfully appealed by the facility within the above timeline. Delayed supplemental or improvement payments will be made on a per diem basis at the respective per diem rate established by the respective rate year calculation. No rate year's per diem calculations will be altered by delayed payments, and no primary Tier 2 and 3 payments and improvement payments originally made to other facilities will be affected by delayed payments. A facility eligible for a delayed payment will receive the established Tier 2 or Tier 3 per diem, based on its own quality of care score. An facility eligible for a delayed payment will receive the established improvement per diem, if its improvement score ranks in the top 20th percentile when included in the ranking of all eligible facilities. If the computed delayed payments for the current Fiscal Year total less than the $2,000,000 in the delayed pool, any remaining fund balance plus interest from this delayed payment pool will be used to fill the subsequent Fiscal Year's delayed payment pool. If the $2,000,000 in the delayed pool is insufficient to pay all computed delayed payments for the current Fiscal Year, additional funds will be made available by deducting from next Fiscal Year's total payment pool so that all facilities eligible for a delayed payment will be paid their computed payments in full. Annually, the pool amounts will be updated in the state plan and will be based on funds derived from general fund related to setting aside 1% of the weighted average Medi-Cal per diem rate, plus the savings from the Professional Liability Insurance being applied at the 75th percentile and the administrative penalties collected for facilities' failure to meet the nursing hours per patient day requirement, minus administration costs.

C. For the rate year beginning on August 1, 2016, the Department will pay an annual lump sum Medi-Cal supplemental payment (as computed in paragraphs B.6 and B.7 above), by April 30, 2016 (and delayed payments by June 30, 2018), to eligible skilled nursing facilities, based on the following performance measures as specified in W&I Code Section 14126.022 (i), as in effect on June 2016:

1. Influenza Vaccination: Short Stay
2. Pheumococcal Vaccination: Short Stay
3. Facility Acquired Pressure Ulcer Incidence
4. The use of physical restraints.
5. Urinary Tract Infection
6. Control of Bowel or Bladder
7. Self-Reported Pain: Short Stay
8. Self-Reported Pain: Long Stay
9. Activities of Daily Living: Long Stay
10. Direct Care Staff Retention

a. The Department will determine a facility ineligible to receive supplemental payments if the facility fails to meet the following minimum qualifying criteria:

   i. A facility fails to timely provide supplemental data as requested by the Department.

   ii. CDPH determines that a skilled nursing facility fails to meet the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

   iii. For the performance period, facility has Class AA/A citations. These citations are issued due to serious harm or death of a resident.

   iv. For the audit period, facility does not have any Medi-Cal bed days. Furthermore, facility must have Medi-Cal Fee-For-Service bed days in the payment period in order to receive a Medi-Cal Fee-For-Service supplemental payment.