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State/Territory Name: CA

State Plan Amendment (SPA) #: CA-22-0061

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

December 5, 2022

Jacey K. Cooper
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 Transmittal Number 22-0061

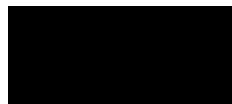
Dear Ms. Cooper:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 22-0061. Effective August 1, 2022, this amendment revises the reimbursement rate methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 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 22-0061 is approved effective August 1, 2022. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Mark Wong at (415) 744-3561 or mark.wong@cms.hhs.gov.

Sincerely,



Rory Howe
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER

2. STATE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY ___ $ ___
b. FFY ___ $ ___

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
, 10

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
, 10

9. SUBJECT OF AMENDMENT

10. 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:
Please note: The Governor's Office does not wish to review the State Plan Amendment.

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME

13. TITLE

14. DATE SUBMITTED
September 22, 2022

15. RETURN TO

FOR CMS USE ONLY

16. DATE RECEIVED
September 22, 2022

17. DATE APPROVED
December 5, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
August 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Pen-and-ink change made to Boxes 7 and 8 by CMS with state concurrence.

(b) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(i) Addressing a grievance or negotiating or administering a collective bargaining agreement.
(ii) Allowing a labor organization or its representatives access to the provider's facilities or property.
(iii) Performing an activity required by federal or state law or by a collective bargaining agreement.
(iv) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

III. AUDITS

A. Except for DP/NFs, subacute, pediatric subacute, NF-As, and state-operated facilities, a minimum of 15 percent of cost reports will be field audited by the Department each year. Facilities identified for audit shall be selected on a random sample basis, except where the entire universe of a class is selected for audit. Field audits may be restricted to facilities that have a complete year of reporting. The sample size for each shall be sufficiently large to reasonably expect, with 90 percent confidence, that it will produce a sample audit ratio which varies from the estimated class population audit ratio by not more than two percent. Other facilities may be audited as necessary to ensure program integrity. The results of federal audits, where reported to the State, may also be applied in determining the audit adjustment for the ongoing rate study.

B. The labor data reported by providers shall be audited. In the event that facilities are inconsistently reporting their labor costs in the OSHPD data, the Department will adjust the data utilized to develop the labor index so that the correct amount will be reflected. If the labor data used in developing the labor index is adjusted, the State Plan will be amended to provide the specific methodology for such adjustments.

C. Reports of audits shall be retained by the State for a period of not less than three years, in accordance with 42 CFR 433.32. Reports shall be retained beyond three years if audit findings have not been resolved.

D. Providers will have the right to appeal findings which result in an adjustment to program reimbursement or reimbursement rates. Specific appeal procedures are contained in Section 14171 of the Welfare and

Institutions Code, and Article 1.5 (Provider Audit Appeals) of Title 22, California Code of Regulations. See Appendix 2.

E. When facilities being audited have more than one cost report with an end date in the audit year, the last report will be the one audited, except in those cases where a facility-specific audit adjustment will be applied or actual audited costs are used. In these cases, all cost reports with an end date in the audit year will be audited.

F. All state-operated facilities will be subject to annual audits.

G. Cost reports for nursing facilities that are distinct parts of acute care hospitals may be audited annually.

H. All subacute and pediatric subacute providers will be subject to annual audits.

IV. PRIMARY REIMBURSEMENT RATE METHODOLOGY

Reimbursement rates shall be reviewed by the Department at least annually. Prospective rates for each class shall be developed on the basis of cost reports submitted by facilities. The following method shall be used to determine rates of reimbursement for a class of facilities when cost reports are available:

A. Audit Adjustment.

1. An audit adjustment shall be determined for each of the following classes:

(a) NF level B field audited facilities with 1-59 beds.
(b) NF level A field audited facilities with no bedsize category.
(c) NF level B field audited facilities with 60+ beds.
(d) ICF/DD field audited facilities with 1-59 beds.
(e) ICF/DD field audited facilities with 60+ beds.
(f) ICF/DD-H field audited facilities with combined bedsizes.
(g) ICF/DD-N field audited facilities with combined bedsizes.

2. A facility's actual audited costs shall be used in developing the class's rate. If a facility's reported costs were not audited and the audit sample exceeds 80 percent of the universe in a class, the class average audit adjustment shall be applied to the costs reported by unaudited facilities. If the audit sample does not exceed 80 percent of the universe in a class, no audit adjustment shall be applied to the costs reported by unaudited facilities. This paragraph does not apply to facilities specified in paragraph 3.

M.1. (a) Effective August 1, 2022, reimbursement rates for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD- Habilitative (ICF/DD- H), and ICF/DD-Nur sing (ICF/DD- N) will be established at the 65th percentile projected for the facility's respective peer group (licensed facility type and bedsize category) in accordance with IV.A through IV.F of this Attachment. DHCS will utilize reported or audited costs with fiscal periods ending in the calendar year that is two years prior to the beginning of the rate year (August 1) to establish each facility's projected rates (e.g., facility's cost report ending on or within January 1, 2020, through December 31, 2020 will be used to calculate the rates for the period from August 1, 2022, through July 31, 2023).

(b) Effective August 1, 2022 through the last day of the COVID-19 Public Health Emergency, the reimbursement rate for ICF/DDs, ICF/DD- Hs, and ICF/DD- Ns shall be the greater of the: (1) reimbursement rate established pursuant to paragraph (a), or (2) the reimbursement rate in effect for the facility on July 31, 2022, inclusive of the temporary rate increase in accordance with pages 90g – 90l of Section 7.4 of the State Plan (COVID-19 Medicaid Disaster Relief) and any supplemental payment received as described in pages 35 – 35a of this Attachment.

(c) For dates of service after the last day of the COVID-19 Public Health Emergency, the reimbursement rate for ICF/DDs, ICF/DD- Hs, and ICF/DD- Ns shall be the greater of the: (1) reimbursement rate established pursuant to paragraph (a); or (2) the reimbursement rate in effect for the facility on the last day of the COVID-19 Public Health Emergency, inclusive of the temporary rate increase in accordance with pages 90g – 90l of Section 7.4 of the State Plan (COVID-19 Medicaid Disaster Relief) and any supplemental payment received as described in pages 35 – 35a of this Attachment.

(d) The reimbursement rates resulting from the application of this Paragraph M.1 will be published on the DHCS website at the following link: http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.ICF_DD.aspx.

2. DHCS will audit ICF/DDs, ICF/DD- H and ICF/DD-N facility cost reports in accordance with III.A, IV.A 1, and IV.A.2 of this Attachment (at pages 9 and 10, respectively). Each ICF/DD, ICF/DD- H, and ICF/DD- N will retain its supporting financial and statistical records for a period of not less than three years following the date of submission of its cost report and will make such records available upon request to authorized state or federal representatives, as described in Welfare and Institutions Code, section 14124.1.

Supplemental Payment Program for Intermediate Care Facilities For The Developmentally Disabled, Including Habilitative And Nursing Facilities

A. Scope and Authority

This program provides supplemental payments to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD- N). The supplemental payments will be provided for dates of service beginning August 1, 2017 through July 31, 2022. State-owned ICF/DD facilities are excluded from the supplemental payment.

B. Supplemental Payment Methodology

The supplemental payment program for ICF/DD, ICF/DD-H, and ICF/DD-N facilities will consist of the following:

1. Supplemental payments calculated based on the difference between the rate methodology applied to the 2017-18 rate year as described in Attachment 4.19-D, Section IV, paragraph M, which is frozen at the 2008-09 65th percentile increased by 3.7%, and the unfrozen 2017-18 65th percentile rate. The unfrozen 2017-18 65th percentile rate is the rate that would have been calculated in Attachment 4.19-D, Section IV, without the application of paragraphs K through M.

2. The total fee-for-service supplemental payment amount for each facility will be calculated based on the supplemental payment peer group 2017-18 per diem differential, as described in B 1., multiplied by the facility's total Medi-Cal fee-for-service days claimed for dates of service during each respective rate year. Facilities in peer groups in which the unfrozen 2017-18 65th percentile rate is lower than the 2017-18 reimbursement rate will not receive the supplemental payment.

3. The supplemental payments will be paid concurrently with the reimbursement rates the facilities receive under the current reimbursement methodology, as described in State Plan Amendment 4.19-D. Thus, the total reimbursement amount that an eligible facility will receive for services rendered during each respective rate year, is the sum of the facility's reimbursement rate under the current reimbursement methodology and the supplemental payment.

4. The total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit. If the supplemental payments for eligible ICF/DD; ICF/DD-H; and ICF/DD-N facilities, as computed above, result in total Medi-Cal payments that exceed the federal upper payment limit for each respective rate year, each provider's total supplemental payment must be reduced pro- rata so that total payments would be equal to the amount available in the federal upper payment limit.