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State/Territory Name: CA

State Plan Amendment (SPA) #: CA-23-0006

This file contains the following documents in the order listed:

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

May 20, 2024

Tyler Sadwith
State Medicaid Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: California State Plan Amendment Transmittal Number 23-0006

Dear State Medicaid Director Sadwith:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed California state plan amendment (SPA) to Attachment 4.19-D CA-23-0006, which was submitted to CMS on March 8, 2023. This plan amendment updates the rate setting methodology for freestanding skilled nursing facilities Level -B and freestanding adult subacute facilities and provides an aggregate five percent increase in the statewide weighted average labor rate component and an aggregate two percent increase in the statewide weighted average non-labor rate component for the calendar year 2023 rate year.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Mark Wong at 415-744-3561 or via email at 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: 23-0006

2. STATE: CA

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
January 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Title 42 § CFR 447 Subpart B & C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ ~~56,400,000~~ 81,100,000
b. FFY 2024 $ ~~18,800,000~~ 27,050,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 4 to Attachment 4.19-D, ~~pages 5a, 5b, 17a, and 17b~~
pages 1, 5a, 5b, 17a, 17b, 19

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 4 to Attachment 4.19-D, ~~pages 5a and 17a~~
pages 1, 5a, 17a, 19

9. SUBJECT OF AMENDMENT
Renew and amend reimbursement methodology for Freestanding Skilled Nursing Facility Level-B & Freestanding Subacute Facilities

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
[redacted]

12. TYPED NAME
Jacey Cooper

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
March 8, 2023

15. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR CMS USE ONLY

16. DATE RECEIVED
March 8, 2023

17. DATE APPROVED
May 20, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
Pen-and-ink changes made to Boxes 6, 7, and 8 by CMS with state concurrence.

Instructions on Back

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: 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 Care 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. SB 853, signed into law on October 19, 2010, as Chapter 717 of the Statutes of 2010, extends the operative date to July 31, 2012. ABX 119, signed into law on June 28, 2011, as Chapter 4 of the Statutes of 2011, extends the operative date to July 31, 2013. AB 1489, signed into law on September 27, 2012, as Chapter 631 of the Statutes of 2012, extends the operative date to July 31, 2015. AB 119 (Chapter 17, Statutes of 2015) extends the operative date to July 31, 2020. Assembly Bill 81 (Chapter 13, Statutes of 2020) extends the operative date to December 31, 2022, and directs the department to make various revisions to the methodology. AB 186 (Chapter 46, Statutes of 2022) reformed the financing methodology applicable to long-term care freestanding nursing facilities level-B and subacute facilities. The financing methodology authorized by AB 186 is effective January 1, 2023 through December 31, 2026.

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. August 1, 2020 through December 31, 2020 shall be a rate period, effective August 1, 2020. Beginning January 1, 2021, the rate year shall be the calendar year.

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

care: additional labor costs attributable to the COVID-19 Public Health Emergency including, but not limited to, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to nonmanagerial workers, and other appropriate costs that support the delivery of patient care. Other appropriate costs that support delivery of patient care include, but is not limited to, personal protective equipment, COVID-19 testing, infection control measures and equipment, and staff training.

J. For calendar year 2023, the audit conducted pursuant to paragraph I of this Section shall include an audit of revenues associated with the COVID-19 Public Health Emergency declared pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, and any renewal of that declaration, and amounts equivalent to the COVID-19 10% per diem rate increase authorized in paragraph R.2 on page 17a, that are received by a facility that were spent on additional labor costs attributable to the COVID-19 Public Health Emergency. Additional labor costs attributable to the COVID-19 Public Health Emergency may include, but is not limited to, increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, and overtime payments to nonmanagerial workers.

Increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, overtime payments to nonmanagerial workers or other additional labor costs shall qualify for purposes of this paragraph if they were either of the following:

1. Implemented prior to January 1, 2023, and continued during the 2023 calendar year, or
2. Implemented on or after January 1, 2023.

If the Department finds that a facility spent less than 85 percent of revenues associated with the COVID-19 Public Health Emergency on additional labor costs during calendar year 2023, the Department will recoup the difference between the amount spent on additional labor costs and 85 percent of Medi-Cal payments received by the facility associated with the COVID-19 10% per diem rate increase authorized in Section 7.4 of the State Plan and amounts equivalent to the COVID-19 10% per diem rate increase authorized in paragraph R.2 on page 17a.

V. Methods and Standards for Establishing FS/NF-B Reimbursement Rates

A. Effective August 1, 2005, a FS/NF-B's actual reimbursement rate (per diem payment) is the amount the Department will reimburse to a FS/NF-B for services rendered to an eligible resident for one resident day. The per diem payment is calculated prospectively on a facility-specific basis using facility-specific data from the FS/NF-B's most recent cost report period (audited or adjusted), supplemental schedules, and/or other data determined necessary by the Department.

O. Beginning with the rate period of August 1, 2020, through December 31, 2020, the increase in the weighted average Medi-Cal reimbursement rate shall be 3.62 percent of the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

P. For the calendar year 2021 rate year, the increase in the weighted average Medi-Cal reimbursement rate shall be 3.5 percent of the weighted average rate from the previous rate period, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

Q. For the calendar year 2022 rate year, the increase in the weighted average Medi-Cal reimbursement rate shall be 2.4 percent of the weighted average rate from the previous rate period, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

R. For the calendar year 2023 rate year, the increase in the weighted average Medi-Cal reimbursement rate shall be calculated separately for labor and non-labor costs, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. For the labor cost category, the annual aggregate increase shall be 5 percent of the weighted average rate attributed to labor costs from the previous year. For the non-labor cost categories, including indirect care non-labor cost, administrative cost, professional liability insurance, capital cost, and direct pass through categories, as specified in Section V, paragraph B on page 6 of this Supplement, the annual aggregate increase shall be 2 percent of the weighted average rate attributed to non-labor costs from the previous year. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

1. For purposes of this calculation, the labor cost categories are summed to calculate the labor rate component, and the non-labor cost categories are summed to calculate the non-labor rate component. For each of the labor and non-labor rate components, a facility's rate component will not decrease for calendar year 2023 relative to calendar year 2022, unless the facility's sum of projected costs for calendar year 2023 decreased compared to the facility's sum of projected costs for calendar year 2022 for that rate component.

2. The facility-specific rate will include the COVID-19 10% per diem rate increase authorized on pages 90g – 90l of Section 7.4 of the State Plan. In the event the COVID-19 Public Health Emergency expires prior to December 31, 2023, the rates established for the calendar year 2023 rate year, including the COVID-19 10% rate increase, will not be decreased and will continue for the duration of calendar year 2023.

3. The COVID-19 10% per diem rate increase authorized on pages 90g – 90l of Section 7.4, or the amounts equivalent to the COVID-19 10% per diem rate increase authorized in paragraph 2 above, whichever remains in effect on December 31, 2023, shall be discontinued for dates of service on or after January 1, 2024.

4. To apply this growth limit to facilities with newly established rates pursuant to Section VIII, the final labor and non-labor rate components shall be computed by multiplying the following two factors:

    a. The respective rate component projected pursuant to Section V, including applicable peer group limits, before applying the rate growth limit described in this section.

    b. The ratio of the following two factors, calculated using data from all facilities with available rates at the time of the rate study:

        i. The Medi-Cal utilization weighted average amounts of the respective rate component after applying the rate growth limit described in this section.

        ii. The Medi-Cal utilization weighted average limit amounts of the respective rate component before applying the rate growth limit described in this section.

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

A. State-owned and operated FS/NF-Bs 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, in a location not previously licensed as a FS/NF-B, or an existing facility newly certified to participate in the Medi-Cal program will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. The Department will calculate a newly established rate for the facility once a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.

C. FS/NF-Bs that have a change of ownership or changes of the licensed operator where the previous provider participated in the Medi-Cal program, the new owner or operator will continue to receive the reimbursement rate of the previous provider. The reimbursement rate of the previous owner will continue to be updated annually pursuant to Section V of this Attachment using the most recent available audited cost report data until a newly established rate is calculated for the facility. The Department will calculate a newly established rate for the facility once a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited for a reporting period beginning after completion of the change of ownership or change of the licensed operator. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.

D. 1. FS/NF-Bs decertified for less than six months and upon recertification will continue to receive the reimbursement rate in effect prior to decertification. The Department will calculate a newly established rate for the facility when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.

2. FS/NF-Bs decertified for six months or longer and upon recertification will receive a reimbursement rate based on the peer-group weighted average Medi- Cal reimbursement rate. The Department will calculate a newly established rate for the facility once a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective at the beginning of each rate period or rate year, as applicable.