Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

06-017*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Instruction:

1. On Attachment 4.19-D after page 22, insert new pages 23-29.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

IX. STATE VETERANS HOMES SUPPLEMENTAL REIMBURSEMENT

This segment of the State Plan describes supplemental reimbursement for a State Veterans Home that is operated by California Department of Veterans Affairs (CDVA), which meets specified requirements, and provides skilled nursing services to Medi-Cal beneficiaries.

A. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity continuously has all of the following characteristics during Department of Health Care Services' (DHCS') rate year beginning August 1, 2006, and subsequent rate years:

1. Provides skilled nursing services to Medi-Cal beneficiaries.
2. Is a State home for Veterans, as defined in United States Code Title 38 (Veterans Benefits), Part 1, Chapter 1, Section 101.
3. Is operated by the State of California.

CDVA must provide reliable data, cost reports, and other information for the computation of the facility's allowable cost incurred for the provision of covered routine and ancillary skilled nursing services to Medi-Cal beneficiaries.

B. Supplemental Reimbursement Methodology

1. The expenditures reported to DHCS by CDVA, represents the allowable cost incurred for the provision of covered routine and ancillary skilled nursing services to Medi-Cal beneficiaries. Such costs are based on the cost reporting form CMS-2540 for freestanding nursing facilities and CMS-2552 for hospital-based nursing facilities. CDVA will use the CMS-2540 or CMS-2552 to determine total allowable cost and apportion that cost to Medi-Cal services in accordance with the established CMS-2540 and CMS-2552 apportionment methodology. See Paragraph F for detailed cost determination protocol.

2. For each facility, the net Medi-Cal cost which may be certified to DHCS for purposes of claiming federal financial participation (FFP) pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations (CFR) is the total allowable Medi-Cal cost as determined pursuant to Paragraph B.1 less all other payments received by CDVA for covered Medi-Cal routine and ancillary skilled nursing services, including any base Medi-Cal per diem payments and any allowable beneficiary and third party payments; except as otherwise noted in this segment of the State Plan or specifically exempted by applicable federal law or regulation. Total computable supplemental reimbursement under this Section IX that is the basis for the claim for FFP will not be deducted from the allowable Medi-Cal cost for purposes of determining the net Medi-Cal cost which may be certified.

3. Pursuant to Section 202 of the Veterans Health Program Improvement Act of 2004, per diem payments made by the federal Department of Veterans Affairs to the State as payments for nursing home care provided to Medi-Cal eligible veterans in a facility recognized as a state home for nursing home care will not be used to offset or reduce the Medicaid reimbursement amount for the provision of nursing home services to Medi-Cal beneficiaries.

4. The total computable supplemental reimbursement that is the basis for the claim for FFP under this program must not be greater than the difference between total allowable cost for Medi-Cal covered skilled nursing services and the total reimbursement received by the facility for such services, including the amount paid under the reimbursement methodology specified in supplement 4 to this Attachment 4.19-D, Section VIII.A (at page 17).

5. The total Medi-Cal reimbursement received by a facility eligible under this program, when combined with the amount received from other sources of payment for covered Medi-Cal skilled nursing facility services (except as exempted in paragraph 3 above), will in no instance exceed 100 percent of costs for covered Medi-Cal skilled nursing services at each facility.

C. Facility Reporting Requirements

CDVA will do all of the following:

1. Certify that the claimed expenditures for skilled nursing services are eligible for FFP pursuant to Section 433.51 of Title 42 of the CFR.

2. Provide evidence supporting the expenditures reported as specified by DHCS.

3. Submit data, as specified by DHCS, to determine the appropriate amounts to claim as expenditures qualifying for FFP, including the annual submission of the cost reporting form CMS-2540 or CMS-2552 to the DHCS and any supplemental schedules to compute the net allowable Medi-Cal skilled nursing services cost.

4. Keep, maintain, and have readily retrievable, such records as specified by DHCS to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the Centers for Medicare & Medicaid Services (CMS).

D. Interim Supplemental Payments, Initial and Final Reconciliations

Reimbursement to a veterans home that is operated by the state, as identified in Paragraph A, will be based on allowable Medi-Cal skilled nursing facility (SNF) costs. The methodology for computing such costs and the required procedures for claiming FFP is detailed in the Supplemental Reimbursement Methodology, Paragraph B and in the Cost Determination Protocol, Paragraph F.

1. Interim Supplemental Payments

DHCS is authorized to make interim Medi-Cal supplemental payments to eligible veterans homes identified in Paragraph A. The interim payment for each facility is based on the facility's estimated annual net allowable Medi-Cal cost, computed in accordance with the Cost Determination Protocol in Paragraph F. However, for interim payment purposes, the cost, day and charge, and payment data used will be for the most recent fiscal period for which an as-filed cost report is available. DHCS will divide the estimated annual net allowable Medi-Cal cost by four to arrive at the eligible expenditure amount for each quarter. The quarterly expenditure amount is the basis for the interim Medi-Cal supplemental payments, to be made each quarter during the fiscal year.

2. Initial Reconciliation

a. As determined pursuant to the methodology in paragraph B, the interim supplemental payments will be reconciled based on the facility's as-filed cost report that is submitted to DHCS five months after the close of the facility's spending fiscal year (the spending fiscal year is the actual service period for which the State is providing the supplemental reimbursement to the facility and for which the actual

expenditure for FFP is being computed). During this initial reconciliation, net allowable Medi-Cal cost will be computed using cost, day and charge, and payment data for the spending fiscal year covered by the as-filed cost report. Updated California Medicaid Management Information System (CA-MMIS) reports and facility specific data will be used to determine payments for the Medi-Cal services in the initial reconciliation for the spending fiscal year covered by the as-filed cost report. Actual net allowable Medi-Cal cost will be reduced by all payments received for Medi-Cal beneficiaries for the spending period, except as provided for in paragraph B.3 above.

b. If at the end of the initial reconciliation it is determined that the eligible facility has been overpaid, the facility will repay the Medi-Cal program, and DHCS will follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If at the end of the initial reconciliation, it is determined that the eligible facility has been underpaid, the facility will receive an adjusted payment amount.

c. Reconciliation will be made on a date-of-service basis. Adjustments for prior year payments must be properly accounted for on the CMS 64.P.

d. All cost report information for which Medi-Cal payments are determined and reconciled are subject to CMS review and must be furnished upon request.

3. Final Reconciliation

a. Within three years after the as filed cost report is submitted, all payments will be reconciled to the facility's finalized spending year cost report as audited and settled by DHCS. During the final reconciliation, net allowable Medi-Cal cost will be computed using cost, day and charge, and payment data for the spending fiscal year as finalized by DHCS during its audit and settlement process. Updated California Medicaid Management Information System (CA-MMIS) reports and facility specific data will be used to determine final payments for the Medi-Cal services in the final reconciliation. Actual net allowable Medi-Cal cost is compared to the interim payments, including any initial reconciliation payments, made for the spending period.

b. If at the final reconciliation, it is determined that the eligible facility has been overpaid, the facility will repay the Medi-Cal program, and DHCS will follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If at the end of the final reconciliation, it is determined that the eligible facility has been underpaid, the facility will receive an adjusted payment amount

c. Reconciliation will be made on a date-of-service basis. Adjustments for prior year payments must be properly accounted for on the CMS 64.P.

d. DHCS will complete the final reconciliation for the claiming period within four years after the postmark date of the as-filed cost report.

E. Department's Responsibilities

1. DHCS will submit claims for FFP for the expenditures as specified in paragraph B.2 above for services that are allowable expenditures under federal law.

2. DHCS will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for FFP will include only those expenditures that are allowable under federal law.

3. Total Medi-Cal reimbursement under this segment of the State Plan will not exceed any applicable federal upper payment limit.

4. DHCS has in place a public process, which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act.

5. DHCS will audit and settle the cost reports filed by the facilities in determining the actual Medi-Cal expenditures eligible for this supplemental payment. DHCS will follow Medicare cost principles and Medicare cost reporting methodologies in determining allowable costs, in accordance with CMS Provider Reimbursement Manual, Parts I and II and 42 CFR 413, and other applicable federal directives which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning allowable costs to program beneficiaries.

F. Cost Determination Protocol

Each facility will follow the following steps in the determination of each facility's net allowable cost incurred for the provision of covered skilled nursing services to Medi-Cal beneficiaries:

1. Freestanding Skilled Nursing Facilities (CMS-2540) -

   a. For the SNF routine cost center, the CMS-2540 computes an allowable cost per day amount on Worksheet D-1, Part I, line 16. To compute the allowable Medi-Cal routine cost, the number of covered Medi-Cal SNF days for the cost reporting period, extracted from the CA-MMIS paid claims report, is multiplied by the allowable cost per day amount from Worksheet D-1.

   b. For each ancillary cost center, the CMS-2540 computes a cost-to-charge ratio on Worksheet C, column 3, lines 21 to 33. To compute the allowable Medi-Cal ancillary cost for each cost center, the actual Medi-Cal covered ancillary charges for the cost reporting period (either extracted from the CA-MMIS paid claims report or as reported by CDVA based on financial and/or patient accounting records that, for the purpose of auditing, are consistent with Medicare Cost Accounting principles and mapped to the individual cost center) are multiplied by that cost center's cost-to-charge ratio from Worksheet C. The Medi-Cal covered ancillary charges include only the covered services that are reimbursable as skilled nursing facility services under Attachment 4.19-D of the California State Plan and should not include any services that are reimbursed under Attachment 4.19-B as non-institutional services.

   c. The total allowable Medi-Cal cost for the facility is the sum of the total allowable Medi-Cal SNF routine cost from above, in paragraph a. and the total allowable Medi-Cal ancillary cost from above, in paragraph b.

   d. The total allowable Medi-Cal cost is then offset by all payments received for the covered Medi-Cal routine and ancillary skilled nursing services; except otherwise noted herein or specifically exempted by applicable federal law or regulation. The payment offsets include any Medi-Cal base payments from the State, made under Attachment 4.19-D of the State Plan (other than payments made under this Section) and also any payments from the beneficiary or third parties for the covered Medi-Cal skilled nursing services. The net allowable Medi-Cal cost would represent the facility's eligible expenditures for supplemental payment.

2. Hospital-Based Skilled Nursing Facilities (CMS-2552):

   a. For the SNF routine cost center, the CMS-2552 computes an allowable cost per day amount on Worksheet D-1, Part III, on line 67. To compute the allowable Medi-Cal SNF routine cost, the number of covered Medi-Cal SNF days for the cost reporting period, extracted from the CA-MMIS paid claims report, is multiplied by the allowable cost per day amount from Worksheet D-1.

   b. For each ancillary cost center, the CMS-2552 computes a cost-to-charge ratio on Worksheet D-4, column 1, lines 37 to 59. To compute the allowable Medi-Cal ancillary cost for each cost center, the actual Medi-Cal covered ancillary charges for the cost reporting period (either extracted from the CA-MMIS paid claims report or as reported by CDVA based on financial and/or patient accounting records that, for the purpose of auditing, are consistent with Medicare Cost Accounting principles and mapped to the individual cost center) are multiplied by that cost center's cost-to-charge ratio from Worksheet D-4. The Medi-Cal covered ancillary charges include only the covered services that are reimbursable as skilled nursing facility services under Attachment 4.19-D of the California State Plan and should not include any services that are reimbursed under Attachment 4.19-B as non-institutional services.

   c. The total allowable Medi-Cal cost for the facility is the sum of the total allowable Medi-Cal routine cost from above, in paragraph a. and the total allowable Medi-Cal ancillary cost from above, in paragraph b.

   d. The total allowable Medi-Cal cost is then offset by all payments received for the covered Medi-Cal routine and ancillary skilled nursing services; except otherwise noted herein or specifically exempted by applicable federal law or regulation. The payment offsets include any Medi-Cal base payments from the State, made under Attachment 4.19-D of the State Plan (other than payments made under this Section) and also any payments from the beneficiary or third parties for the covered Medi-Cal skilled nursing services. The net allowable Medi-Cal cost would represent the facility's eligible expenditures for supplemental payment.