Table of Contents

State/Territory Name: California

State Plan Amendment (SPA) #: 11-010B

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

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

FEB 27 2013

Dear Mr. Douglas:

Enclosed is an approved copy of California state plan amendment (SPA) 11-010B. The state submitted SPA 11-010 to the Centers for Medicare and Medicaid Services (CMS) on June 30, 2011 to reduce payment rates for various long-term care services by 10 percent. On October 4, 2011, the state split SPA 11-010 into two components (11-010 and 11-010A) to allow the reduction of certain categories of long term care rates (including Nursing Facility - Level A and Distinct Part Nursing Facility Level B) to be approved first under SPA 11-010, while allowing additional time to review the reduction for the remaining categories (intermediate care facility for the developmentally disabled (ICF/DD), pediatric subacute, and rural swing bed services) under SPA 11-010A. On December 23, 2011, the state further split SPA 11-010A into two components (11-010A and 11-010B). The end result of these splits is that SPA 11-010B will provide specifically for a rate reduction for ICF/DD services. The pediatric subacute rate reduction will be provided for in SPA 11-010A, and the state is no longer pursuing a rate reduction for the rural swing bed services.

The original rate reduction proposed in SPA 11-010 for ICF-DD services was a 10 percent reduction from the current rate, which, as approved previously in SPA 08-009D, is the frozen 2008-2009 rate. After various revisions to its proposal, the rate methodology being approved under SPA 11-010B is as follows: ICF-DD services would be reimbursed, effective August 1, 2012, at the facility's projected cost per day plus 5 percent, but no lower than the current rate reduced by 10 percent (the floor) and no higher than the current rate (the ceiling). Under SPA 11-10B, no facility will have its rate reduced from the current rate by more than 10 percent.

Applicable Statutory Requirements

While we review proposed SPAs to ensure their consistency with the relevant provisions of the Social Security Act (the Act), we conducted our review of California's submittal with particular attention to the statutory requirements at section 1902(a)(30)(A) of the Act ("Section 30(A)"). Section 30(A) of the Medicaid Act requires that state plans contain "methods and procedures . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. §

1396a(a)(30)(A). As we explain in greater detail below, we find that the state's submission is consistent with the requirements of the Act, including those set forth in section 1902(a)(30)(A).

States must submit information sufficient to allow CMS to determine whether a proposed amendment to a state plan is consistent with the requirements of section 1902 of the Act. However, consistent with the statutory text, CMS does not require a state to submit any particular type of data, such as provider cost studies, to demonstrate compliance. *See* Proposed Rule, Dep't of Health & Human Servs., Ctrs. For Medicare & Medicaid Servs., 76 Fed. Reg. 26342, 26344 (May 6, 2011). Rather, as explained in more detail in the May 6, 2011 proposed rule, CMS believes that the appropriate focus of Section 30(A) is on beneficiary access to quality care and services. CMS has followed this interpretation for many years when reviewing proposed SPAs.[1]

This interpretation – which declines to adopt a bright line rule requiring the submission of provider cost studies – is consistent with the text of Section 30(A) for several reasons. First, Section 30(A) does not mention the submission of any particular type of data or provider costs; the focus of the Section is instead on the availability of services generally. Second, the Medicaid Act defines the "medical assistance" provided under the Act to mean "payment of *part* or all of the cost" of the covered service. *See* 42 U.S.C. § 1396d(a) (emphasis added). Third, when Congress has intended to require states to base Medicaid payment rates on the costs incurred in providing a particular service, it has said so expressly in the text of the Act. For example, the now-repealed Boren Amendment to the Medicaid Act required states to make payments based on rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). By contrast, Section 30(A) does not set forth any requirement that a state consider costs in making payments. Finally, CMS observes that several federal courts of appeals have interpreted Section 30(A) to give states flexibility in demonstrating compliance with the provision's access requirement and have held that provider costs need not always be considered when evaluating a proposed SPA. *See Managed Pharm. Care v. Douglas,* No. 12–55067, 2012 WL 6204214 at *10-11 (9th Cir. Dec. 13, 2012); *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 853 (3d Cir. 1999); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *Minn. Homecare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam). These decisions suggest that CMS's interpretation of Section 30(A) is a reasonable one. [2]

CMS Review of State Support and Provider Concerns

CMS has reviewed the proposed SPA and, applying our interpretation of Section 30(A), determined that the proposed rate cut is consistent with the requirements of that provision and the Medicaid Act. In reaching this conclusion, CMS relied on the following factors identified by the state in the document titled, "Medi-Cal Fee-For-Service Long-Term Care Access Analysis: Intermediate Care Facilities for the Developmentally Disabled" as justification for the proposed SPA's compliance with Section 30(A)'s access requirement:

[1] *See, e.g.*, Br. of the United States as Amicus Curiae, *Douglas v. Independent Living Ctr.*, No. 09-958, at 9-10 (2010); Br. of United States as Amicus Curiae, *Belshe v. Orthopaedic Hosp.*, 1997 WL 33561790, at *6-*12 (1997).

[2] CMS's interpretation does not, of course, *prevent* states or CMS from considering provider costs. Indeed, for certain proposed SPAs, provider cost information may be useful to CMS as it evaluates proposed changes to payment methodologies. CMS also reserves the right to insist on cost studies to show compliance with Section 30(A) in certain limited circumstances – particularly when considering a SPA that involves reimbursement rates that are substantially higher than the cost of providing services, thus implicating concerns about efficiency and economy.

- California's data analysis evaluated the three types of ICF-DD providers: ICF-DD Habilitative (ICF-DD/H); ICF-DD Nursing (ICF-DD/N); and ICF-DD. ICF-DD/N facilities serve residents with higher nursing needs than the ICF-DD/H facilities, while the ICF-DD facilities are larger facilities that serve a mixture of ICF-DD residents. California looked at the number of providers, number of Medicaid participating providers, available bed days, occupancy/vacancy rates, and Medicaid utilization over the most recent four year period for which cost report data was available at the time (2005-2008). California evaluated these measures from both a statewide perspective as well as a peer grouping perspective (which grouped the California counties into seven peer groups based on similarity in operating costs).

- All three types of ICF-DD providers participate 100 percent in Medicaid, with Medicaid utilization (of the total occupied bed days) being at 99-100 percent, for the entire time period.

- The latest year's data (2008) shows that there are 704 ICF-DD/H facilities with 4.352 licensed beds. The occupancy rate is 93.80 percent. There was a drop in the number of facilities and licensed beds from 2007 to 2008 (by about 2 percent), but occupancy rate actually decreased as well (by about 1 percent),

- The latest year's data (2008) shows that there are 328 ICF-DD/N facilities with 1,985 licensed beds. The occupancy rate is 93.02 percent. There was a drop in the number of facilities and licensed beds from 2007 to 2008 (by about 2.6 percent), and occupancy rate increased (by 1.4 percent),

- The latest year's data (2008) shows that there are ten ICF-DD facilities with 1,037 licensed beds. The occupancy rate is 76.55 percent. There was a drop of one facility from 2007 to 2008, but occupancy rate actually decreased as well (by about 1 percent),

- By peer group (based on similar operating costs), the results follow a somewhat similar pattern as the statewide data. Of note is that the larger ICF-DD facilities are not currently in every peer group. For example, there are no ICF-DD facilities in Peer Group 1, 3, and 4, and there is only one ICF-DD facility in Peer Group 7, where the occupany rate is at 99.75 percent.

From the access analysis, California concluded that there has not been any access issue for the three types of ICF-DD facilities and that the occupancy/vacancy rates indicate additional capacity remains. However, due to some observed data fluctuation, in particular in the number of providers, California determined that a modification to the rate reduction proposal was warranted. Accordingly, California revised the rate reduction methodology to specifically target those providers who are receiving payments above their costs. Using the latest available completed period's cost report data, a facility-specific projected cost per day is computed, with an add-on of 5 percent. Providers would then be reimbursed this cost per day amount, subject to the ceiling of the current frozen 2008-2009 rate and a floor of the current frozen 2008-2009 rate reduced by 10 percent. Under this revised methodology, approximately 64 percent of the providers will be held harmless (since their projected cost per day with the 5 percent cushion is

above the current rate), and 36 percent of the providers will have their rates reduced (since their projected cost per day with the 5 percent cushion is below the current rate). No providers will have their current rate reduced by more than 10 percent. Therefore, the revised methodology is within the parameters of the original proposal of a reduction "up to 10 percent" and the May 27, 2011 public notice issued by the state in accordance with Section 1902(a)(13) of the Act. Note that while CMS does not interpret compliance with Section 30(A) to require the state to conduct a study of provider costs, in this particular case the state did incorporate provider-specific costs into its rate methodology as a way to target the reduction to a smaller number of providers.

In addition to the revised rate methodology, the state has delayed the effective date of the reduction from June 1, 2011 to August 1, 2012 to reduce the retroactive fiscal impact on the affected providers. The state will continue to monitor access in accordance with the approved monitoring plan ("Monitoring Access to Medi-Cal Covered Healthcare Services") that has been incorporated into the state plan Attachment 4.19-F (approved under SPA 08-009B1). Finally, the state has added "trigger language" into this SPA 11-010B to automatically increase the reduced rate back to the current rate (frozen 2008-2009 rate) for 120 days when there is a drop in number of licensed beds of 5 or more percent and the occupancy level is greater than 98 percent. If during the 120 days, the state determines that the drop in beds is due to the rate reduction, the state will submit a new SPA to revise the reduced rates. This trigger language further protects against any arising access problem, and, along with the various actions that the state has taken, supports the state's compliance with Section 30(A) requirements on access.

In spite of these changes, CMS has received numerous complaints from providers and their associations, including the California Association of Health Facilities (CAHF) and the Developmental Services Network (DSN), opposing the ICF/DD reduction. We also received letters from California regional centers who work with individuals with developmental disabilities. We discussed the provider concerns with the state and carefully considered the issues under the parameters of Section 30(A) requirements:

a. Provider concern: The current rate is already frozen at the 2008-2009 level and has already caused a drop in number of facilities.

   State's response: The state's data shows that a drop in number of facilities did occur but this was actually even prior to the effect of the rate freeze taken by the state. The most current data (obtained after the access analysis discussed above) actually showed an increase in number of ICF/DD-H and ICF/DD-N facilities even after the rate freeze took effect as of August 1, 2009 (ICF/DD facility number is steady since the rate freeze).

   CMS: The state sufficiently provided access data in November 2011 to support that there is sufficient access existing in all three ICF/DD categories, consistent with Section 30(A). Furthermore, the state provided additional data to show that the rate freeze that was implemented as of August 1, 2009 has not result in a decreased number of participating facilities.

b. Provider concern: The proposed rate will cut rates by almost 70% for some providers, and hundreds of facilities will close as the reduced rates are inadequate in covering provider's basic costs of providing patient care, including costs of meeting state and federal requirements and mandates.

State's response: The state's latest proposal targets providers who are being reimbursed at a rate in excess of the projected costs and will not apply any further reduction to providers whose projected costs (plus 5% cushion) are higher than the current reimbursement. Furthermore, the per diem rate is supplemented by add-ons for new federal/state mandates that have not already been built in to the provider's cost reports. The state provided data which shows the revised impact to providers. The result, based on preliminary 2012/2013 rate data from the state, is that of 1,117 ICF/DD facilities (all three categories), 718 will not experience any reduction from the current rate (frozen at 2008/2009 level), and 399 will have rates reduced given that projected cost per day plus 5% cushion is below the current rate level.

CMS: We conclude that the state has adequately taken steps in adjusting its rate reduction methodology to address potential risks in beneficiary access consistent with Section 30(A). While it is not required that provider cost is studied as part of the requirement of ensuring access, the state did revise its rate reduction methodology to take into account an individual provider's costs so as to target only providers whose projected costs are lower than the current reimbursement rate (the 2008/2009 frozen rate). This revision materially reduces the number of affected providers. Instead of reducing 100% of the providers' reimbursement by 10%, now 36% of providers would have their rate reduced, and the degree to which an individual provider's rate is reduced is dependent on how much it is being paid above its projected cost (but no provider will have a reduction greater than 10% of the current rate).

c. Provider concern: Projected costs do not accurately reflect actual cost. Projected costs are based on global audit adjustment factors and not provider-specific. Projected costs are based on inaccurate and out-dated cost report data and only consider Medicaid allowable costs rather than full costs incurred by facilities.

State response: In its latest proposal, the state will be computing a facility's projected cost per day based on the most recently available cost report data. The state also maintains that it is the provider's responsibility to report its costs accurately on the cost report, and the state cannot provide reimbursement based on unsubstantiated costs. Furthermore, the state must only recognize costs based on Medicaid cost principles and not all costs incurred by a provider. The state acknowledges that due to resource constraints, it can only audit a statistically valid sample of the ICF/DD-H and ICF/DD-N facilities, and derive a class-wide audit factor based on the audit samples. However, the state believes its proposed reimbursement, which builds in a 5% cushion on top of projected costs, adequately mitigates any concern regarding the use of class-wide audit factor.

(Note that ICF/DD facilities are all individually audited due to the low number of these providers, and there is no need to use a class-wide audit factor.)

CMS: After discussing the issue with the state, we believe that California has chosen a reasonable methodology for estimating allowable costs, and we agree that it is consistent with Section 30(A) requirements regarding economy and efficiency for the state to establish rates that recognized only allowable costs per state- and federally-established cost principles. In establishing reimbursement methodologies and payment rates, the state must balance economy and efficiency with access needs. Furthermore, we do not believe it is inconsistent with federal rules for a state to perform statistically valid sample audits in establishing audit adjustment factors or use prior period costs as part of its rate setting process. Finally, we believe the state building in a 5% cushion into its projected rate is an additional measure it is taking to reduce risk that the rate reduction will be at a level that will result in access problems.

d. Provider concern: Access analysis is based on flawed methodology by using peer grouping that is inappropriate for ICF/DD facilities.

State response: The peer grouping used was originally developed to cluster skilled nursing facilities into county groupings with similar operating costs for rate setting purposes. Since direct care labor represents the majority of facility costs, direct care labor served as the basis for clustering the facilities. The resulting seven peer groups contain counties that are similar in nature. The state believes the peer grouping used in the access analysis is appropriate; the costs employed in the development of the SNF peer groups are applicable to the ICF/DD population to a large extent. The state further argues that the access analysis is consistent with access analysis used for other long term care reductions accepted by CMS. And the state is committed to track beneficiary access through its established monitoring plan and take corrective action as needed.

CMS: CMS does not require states to submit particular data or use particular methodology to measure access or demonstrate compliance with access requirements. We believe the state has developed reasonable metrics as access indicators. The state is evaluating number of providers and Medicaid participating providers, bed size, occupancy/vacancy level, and Medicaid utilization. The ICF/DD access study submitted in November of 2011 was based on the four most recent periods for which audited data is available (2005-2008). The state evaluated the data from a statewide basis as well as by peer grouping based on similar operating costs. We believe the state has reasonably conducted an analysis to demonstrate that there is adequate ongoing access in these particular long-term care services.

e. Provider concern: Reduction would result in business failures, service disruptions, and loss of caregiver jobs. Many of these facilities are operated by families and caregivers and not operated by large corporations. Also closure of

facilities and displacement of residents who have lived in a facility for years or decades carry a significant human cost.

State response: State has taken into consideration the access data and the providers' concerns in modifying its reimbursement methodology. The state believes it is still necessary to modify its current reimbursement to arrive at a methodology that more appropriately reimburses providers while dealing with current budget constraints. The latest proposed methodology targets providers who are reimbursed above costs. The state does not agree that the proposed reimbursement methodology will materially impact access. Furthermore, the state notes that patient transfers occur throughout the state on a daily basis, and that there are well-established approaches to minimize transfer trauma and stress. The state also points out that these small facilities open and close regularly, and the state cannot be responsible entirely for individual facility's decision to continue to operate a business or ensuring employment for caregivers. The state needs to ensure access to care for Medicaid beneficiaries in the most appropriate and cost efficient manner, and it believes its proposed reimbursement methodology achieves this.

CMS: We believe the state has adequately demonstrated that its reimbursement rates for these particular long-term care services are consistent with Section 30(A). It has evaluated relevant data metrics to ensure that there is sufficient capacity in these facilities and that it has a monitoring plan in place to ensure continued access. It also revised its reduction methodology to take into consideration providers' concerns, including using most recently available cost report data in computing a provider-specific projected cost per day and increasing that cost per day amount by a 5% cushion; it has delayed the effective date to reduce the retroactive impact of the reduction.; and it has incorporated trigger language into the state plan that will provide for an automatic increase to the rate for affected providers should an access problem be identified. CMS does not interpret Section 30(A) to require the state to guarantee that no providers will close or drop out of Medicaid participation as a result of payment rate methodology changes. Rather, as California has done here, the state needs to demonstrate that it has methods and procedures to ensure its payments are sufficient to enlist enough providers so that Medicaid beneficiary will have access to care and services as they are available to the general population.

f. Provider concern: Closure of ICF/DD facilities would result in displacement of patients to more costly alternatives such as state development centers. Providers claim that the annual cost per resident at a small ICF/DD facility is $70,000, whereas the cost at a state development center is $300,000.

State response: Again, the state argues that its latest methodology ensures that any additional reduction is only applied to those facilities currently being reimbursed in excess of projected costs and therefore is helping to protect access. It believes there will be sufficient beds available for the Medicaid populations.

CMS: We believe the state has adequately demonstrated that its reimbursement rates for these particular long-term care services are consistent with Section 30(A). While the state cannot guarantee that no ICF/DD facilities will close, the steps that the state has taken provide reasonable assurance that there is sufficient capacity in ICF/DD facilities, that the revised rate reduction methodology materially minimizes the risk of access issues, and that such capacity will be monitored continuously so that any arising access issues will be mitigated and addressed.

g. Provider concern: Further reductions will reduce rates by as much as 30%.

State response: The state has not submitted any SPA that provides for further reduction for future rate years. The state has informed us that at this time there is no definitive plan for future rate years. However, the state is considering that ICF/DD reimbursement for the future rate years will still be based on projected costs plus 5% cushion, subject to the ceiling of the current 2008/2009 frozen rate. The difference may be that the floor to the rate (currently set at current rate reduced by 10%) will be lowered to current rate reduced by 20% in the next year and removed completely the following year. In other words, the state believes by then a provider's reimbursement rate will be gradually reduced to its projected cost plus 5%, for those providers who are currently reimbursed at a rate that is significantly higher than costs.

CMS: We have not received any SPA affecting future rate years. Any future rate reduction will need to be submitted in subsequent SPAs and will be further subject to ongoing access analysis and monitoring.

h. Provider concern: Retroactivity of reduction will cause extreme hardship for the facilities.

State response: The state has delayed the effective date of this ICF/DD reduction SPA from June 1, 2011 to August 1, 2012. The state has also offered that recoupment of retroactive reimbursement will be made based on a withhold of 5% of prospective payments, until the entire retroactive overpayment is collected. The state's established overpayment procedures also allow for alternative repayment options for providers experiencing hardship.

CMS: We conclude that the state has adequately considered the providers' concerns; the state delayed the effective date by fourteen months to reduce the retroactive impact of the reduction.

i. Provider concern: The state failed to provide adequate public notice to its revised rate reduction methodology.

State response: The state's position is that its revised rate reduction methodology is within the parameters of the public notice that it gave originally on May 27, 2011, which provides for "a provider payment reduction up to 10 percent" for various long-term care services, including ICF/DD and pediatric subacute services. The state revised its reduction from the original SPA proposal of 10% as part of the public process, but in no instance will a provider be subject to a reduction greater than the original 10%.

CMS: Consistent with Section 1902(a)(13) of the Act, the state has complied with the public notice requirements. We agree with the state that the public notice provides for a reduction of up to 10%. The state, as part of the public process, revised the reduction based on both public and CMS feedback. The resulting methodology does not reduce payments to any provider by greater than 10% and therefore is within the parameter of the public notice issued.

Summary and Conclusion

CMS concludes that the state has adequately demonstrated that the rate reduction it is proposing for ICF/DD services is consistent with Section 30(A) access requirements. As discussed above, the state demonstrated this through its access data analysis and also by various modifications that it has made to its original proposal to further monitor and reduce potential risk of access issues.

We also conclude that the proposed SPA is consistent with the efficiency and economy requirements in Section 30 (A) of the Act. We have generally considered a proposed payment rate as being inefficient or uneconomical if it was substantially above the cost of providing covered services. *See Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 537 (3d Cir. 2002) ("What sort of payments would make a program inefficient and uneconomical? Payments that are *too high*."). For this reason we do not believe that it is appropriate for states to address potential access concerns by setting rates unreasonably high in relation to costs – such rates would necessarily be neither efficient nor economical. Consistent with this view, HHS has promulgated Upper Payment Limit ("UPL") regulations that "place an upper limit on overall aggregate payments" for certain types of services, 65 Fed. Reg. 60151-01. As these provisions reflect, we believe that states must balance access concerns with efficiency and economy concerns. Applying our interpretation of the statute to the proposed SPA at issue here, we believe that the proposed rates are consistent with efficiency and economy. The state's Medicaid payment rates are within the nursing facility upper payment limit.

As we have explained elsewhere, CMS does not interpret Section 30 (A) of the Act as requiring a state plan by itself to ensure quality of care. As the text of the statute reflects, payments must be consistent with quality of care, but they do not need to directly assure quality of care by themselves. CMS therefore believes that Section 30(A) leaves room to rely on factors external to a state plan to ensure quality of care. In this particular instance, CMS relies on applicable state licensure and regulatory activities applicable to ICF/DD providers. While one could argue that higher payments would result in care above and beyond state licensure standards, the focus is on ensuring the regulatory standard of quality. CMS believes that it is reasonable to assume that ICF/DD providers will continue to meet licensure standards.

In summary, we find that this amendment complies with all applicable requirements and approve this SPA with the effective date of August 1, 2012. Please find enclosed a copy of the CMS-179 form and the approved state plan pages for incorporation into the California state plan.

If you have any questions, please contact Mark Wong by phone at (415) 744-3561 or by email at mark.wong@cms.hhs.gov.

Sincerely,

[redacted]

FEB 27 2013

Cindy Mann
Director, CMCS

Enclosure

cc:

Mari Cantwell, California Department of Health Care Services
Kathyryn Waje, California Department of Health Care Services
Dianne Heffron, FMG, Centers for Medicare and Medicaid Services
Kristin Fan, FMG, Centers for Medicare and Medicaid Services
Janet Freeze, DRSF, Centers for Medicare and Medicaid Services
Christopher Thompson, DRSF, Centers for Medicare and Medicaid Services
Douglas Thomas, DRSF, Centers for Medicare and Medicaid Services
David Hoskins, OGC, Department of Health and Human Services
Tim Weidler, DMCHO, Region 7, Centers for Medicare and Medicaid Services
Gloria Nagle, DMCHO, Region 9, Centers for Medicare and Medicaid Services
Henrietta Sam-Louie, DMCHO, Region 9, Centers for Medicare and Medicaid Services
Don Novo, DMCHO, Region 9, Centers for Medicare and Medicaid Services
Kristin Dillon, DMCHO, Region 9, Centers for Medicare and Medicaid Services
Annalisa Fichera, DMCHO, Region 9, Centers for Medicare and Medicaid Services
Mark Wong, DMCHO, Region 9, Centers for Medicare and Medicaid Services

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: 11-010B

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
~~June 1, 2011~~ ~~January 1, 2011~~
August 1, 2012

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:
AB97 42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2010-2011~~ 2011-12 ~~($7,959,906)~~ ($4,383,683)
b. FFY ~~2011-2012~~ 2012-13 ~~($23,879,718)~~ ($5,044,911)
($1,049,023)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D ~~Page 15.4c.1 & 15.4c.2~~
Pages ~~15.4C~~ 15.4C.1, 15.4C.2, 15.4C.3 and 15.4C.4
Attachment 4.19-F, page 83

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
($6,294,136)
Attachment 4.19-D ~~Page 15.4c.1, 15.4c.2~~
~~Page 15.4C~~
N/A

10. SUBJECT OF AMENDMENT:

Reduced payment rates as mandated by Assembly Bill 97

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:
[redacted]

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: 12/22/11

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:
FEB 27 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
AUG 01 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Krista Fan for Cindy Mann

22. TITLE:
Deputy Director of FMG

23. REMARKS:

M.1. Notwithstanding paragraph F.9 of this Attachment (at page 15) and paragraphs K.6 through K.8, payments to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N), effective August 1, 2012, will be as specified in this paragraph M. The reimbursement rate will be one of the two rates listed below, as applicable:

a. If the facility's total projected costs, increased by 5 percent, are equal to or higher than the 2008-09 65th percentile, the applicable rate will be the 2008-09 65th percentile for the facility's peer group.

b. If the facility's total projected costs, increased by 5 percent, are lower than the 2008-09 65th percentile, the applicable rate will be the facility's total projected costs increased by 5 percent. However, no facility will receive a rate that is lower than the 2008-09 65th percentile for its respective peer group, reduced by 10 percent.

For purposes of subparagraphs M.1.a and M.1.b, DHCS will determine each facility's projected costs by updating the facility's costs taken from cost reports that would have otherwise been used for rate-setting purposes in paragraph F (at page 13) for a given rate year (i.e., facility costs taken from the cost reports ending during State fiscal year July 1, 2010, through June 30, 2011 will be used as a basis for projected costs for the period from August 1, 2012, through July 31, 2013).

2. 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.

3. The reimbursement rate methodology for ICF/DD, ICF/DD-H, and ICF/DD-Ns may include more or less than twelve months and/or more than one cost report, as long as the fiscal periods all end within the timeframe specified for rate-setting.

4. DHCS will exclude any cost report or supplemental schedule or portion thereof that it deems inaccurate, incomplete, or unrepresentative. If any cost report or supplemental schedule is excluded, the rate set forth in paragraph M.10 will apply.

5. ICF/DD, ICF/DD-H, and ICF/DD-Ns that no longer participate in the Medi-Cal Program will be excluded from the rate-setting process.

6. Overpayments to any ICF/DD, ICF/DD-H, and ICF/DD-Ns will be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations. Overpayment recovery regulations are described in the California Code of Regulations, Title 22, Section 51047, as in effect on August 1, 2012.

7. Providers have the right to appeal audit or examination findings that result in an adjustment to Medi-Cal reimbursement rates. Specific appeal procedures are contained in Welfare and Institutions Code, Section 14171, as in effect on August 1, 2012, and in Division 3, Subdivision 1, Chapter 3, Article 1.5 (Provider Audit Appeals) of the California Code of Regulations, Title 22, Sections 51016 through 51048, as in effect on August 1, 2012.

8. New ICF/DD, ICF/DD-H, and ICF/DD-Ns with no cost history in a newly constructed facility, in a location not previously licensed as an ICF/DD, ICF/DD-H, or ICF/DD-N, or an existing facility newly certified to participate in the Medi-Cal Program will receive interim reimbursement at a rate equal to the 2008-09 65th percentile rate for the applicable peer group (licensed facility type and bedsize category). In these circumstances, DHCS will request an audit of the cost report period in which the State issued the new license. At such time that the audit report data reflecting at least six months or more becomes available, the interim rate will be retroactively adjusted to a final rate based on the current methodology.

9. In instances where an existing facility which has participated in the Medi-Cal Program changes ownership or operators, DHCS will reimburse the facility an interim per diem payment rate at the 2008-09 65th percentile of the applicable peer group. The provider will continue to receive the 2008-09 65th percentile at the respective peer group until the new owner or operator has submitted six or more months of Medi-Cal cost and/or supplemental data and DHCS has audited these costs. At such time the audit report data becomes available, the interim rate will be retroactively adjusted to the appropriate final rate based on the current methodology.

10. If any ICF/DD, ICF/DD-H, or ICF/DD-N provider does not complete and submit a cost report for computing the projected cost per day for the upcoming rate year, that provider will receive a rate at the 2008-09 65th percentile established for the peer group in which that provider belongs, reduced by 10 percent. Once a provider submits a cost report applicable to the rate year in which its costs would be used in the calculation of its projected cost per day, DHCS will calculate an individual rate based on the current methodology, and apply that rate retroactively for the rate period.

11. The effect of the reduction specified in paragraph M.1 will be monitored in accordance with the access monitoring plan in Attachment 4.19-F.

12. Notwithstanding Sections III.A, IV.A.I and IV.A.2 of this Attachment (at pages 9 and 10), effective with the 2012-13 rate year, DHCS will use audited costs in determining rates for those facilities which were audited, and will apply the ICF/DD-H and ICF/DD-N audit adjustment factors (as described in Section IV.A) to facilities which were not audited.

13.a (i) In the event that DHCS determines, pursuant to subparagraph M.13.b, that reduced per-diem reimbursement rates calculated using the methodology specified in subparagraph M.1 may be insufficient to enlist or maintain participation of providers of ICF/DD services, DHCS will institute a per-diem rate for a 120 day review period for facilities statewide that will be equal to the per-diem reimbursement rates in effect for the 2008-09 rate-year. DHCS may adjust the per-diem rate for one or more mandates that are applicable to the providers of ICF/DD services.

(ii) In the event that DHCS determines, pursuant to subparagraph M.13.b, that reduced per-diem reimbursement rates calculated using the methodology specified in subparagraph M.1 may be insufficient to enlist or maintain participation of providers of ICF/DD-H or ICF/DD-N services, DHCS will institute a per-diem rate for a 120 day review period for facilities in a geographic area (as defined in paragraph 13.d) that will be equal to the per-diem reimbursement rates in effect for the 2008-09 rate year. DHCS may adjust the per-diem rate for one or more mandates that are applicable to the providers of ICF/DD-H or ICF/DD-N services.

b. The determination described in subparagraphs M.13.a(i) and M.13.a(ii) will be made when the number of licensed beds decreases by 5 percent or more, relative to when the per-diem reimbursement rate decrease took effect, in either of the following:

- ICF/DDs statewide, if the total resident occupancy level statewide is equal to or in excess of 98 percent.

- An ICF/DD-H or ICF/DD-N geographic area (as defined in paragraph 13.d) where the total resident occupancy level is equal to or in excess of 98 percent.

The number of licensed beds will be measured on an ongoing basis, and the occupancy levels will be measured on a quarterly basis in accordance with the DHCS' monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services".

c. The 120-day review period will begin on the date that DHCS notifies CMS of its intention to increase the rate. DHCS will also notify the affected providers of the effective date of the rate increase, and will provide the data that triggered the rate change.

d. A geographic area is defined as a geographic peer-group for purposes of this Paragraph M. A listing of the counties comprising each geographic peer-group can be found in Section V, at page 18 of Supplement 4 to Attachment 4.19-D.

e. In conjunction with the reinstatement of per-diem reimbursement rates to the 2008-09 levels for a given geographic peer-group for ICF/DD-H and ICF/DD-N, and ICF/DD statewide, DHCS shall have a period of 120 days to conduct an analysis of the extent to which reduced per-diem reimbursement rates may have resulted in the decrease in the number of licensed beds. Once DHCS has concluded its analysis, it shall notify Centers for Medicare & Medicaid Services' Regional Office and affected providers of its final determinations and provide the data in support of DHCS' analysis and conclusion. DHCS will then take one of the following actions:

   (i) Restore the reduced per-diem reimbursement rates previously in effect, because DHCS' analysis determined that the decrease in the number of licensed beds was not related to the reduced per-diem reimbursement rates.

   (ii) Submit another SPA within the next 90 days following the initial 120 days to adjust the per-diem reimbursement rates. The higher rates paid under paragraphs 13.a(i) and (ii) shall remain in effect as the reimbursement rates up to the effective date of the new SPA. The higher rates paid under paragraphs 13.a(i) and (ii) shall also continue to be paid, as interim rates, from the effective date of that new SPA until that SPA is approved; the rates approved under the new SPA will then be retroactively applied back to the effective date of that SPA.

f. The effective date for making the determination set forth in subparagraph 13.b will be based on the effective date of SPA 11-010B (that is August 1, 2012). For purposes of this determination, each facility category as identified in subparagraphs 13.a(i) and 13.a(ii) will be examined separately.

g. The reimbursement rates resulting from the application of this Paragraph M.12 will be published on the DHCS website at the following link: http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx.

Long Term Care Addendum to "Monitoring Access to Medi-Cal Covered Healthcare Services"

Effective January 1, 2013, Department of Health Care Services (DHCS) shall conduct quarterly access monitoring for all subject long term care facilities licensed as skilled nursing facilities or intermediate care facilities by updating the previous quarterly occupancy levels on a facility-specific basis using admissions and discharge data obtained through the MDS 3.0 quarterly submissions. The update for the first quarter of each rate-year will be based on the annual access analysis, which will utilize audited annual occupancy data obtained from DHCS' Audits and Investigations program. Licensed beds will be adjusted, if necessary, for each facility using data obtained from the California Department of Public Health's Licensing and Certification program. In the case of subacute facilities, certified-beds data will be obtained from DHCS' Safety Net Financing Division. The same approach will be utilized for the intermediate care facilities for the developmentally disabled, including habilitative and nursing, but using paid claims and managed-care encounter data for determining utilization, since these facilities are not subject to the MDS submission requirements. DHCS will submit the long term care facilities access monitoring results to CMS quarterly.