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State/Territory Name: California

State Plan Amendment (SPA) #: 19-0022

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 S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

September 26, 2019

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: State Plan Amendment (SPA) 19-0022

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 19-0022. This amendment proposes to continue the supplemental payment for intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), for the service period from August 1, 2019 to December 31, 2021.

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. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of August 1, 2019. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Mark Wong at (415) 744-3561.

Sincerely,

[redacted]

Kristin Fan
Director

cc:
Richard Kimball
Mark Wong

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: 19 — 00 22

2. STATE: California

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: August 1, 2019

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: Title 42 § CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT
a. FFY 18/19 $ 1,767,483
b. FFY 19/20 $ 10,604,900

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Pages 35-35a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D, Pages 35

10. SUBJECT OF AMENDMENT

Extension of the time-limited supplemental payment for Intermediate Care Facilities for the Developmentally Disabled, including Habilitative and Nursing facilities, using California Healthcare, Research and Prevention Tobacco Tax Act (Commonly known as Proposition 56). The supplemental payment extension would be for services rendered on or after August 1, 2019 through December 31, 2021.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: August 22, 2019

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED: SEP 26 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS

For Box 7 "Federal Budget Impact", please note the additional information:
c. FFY 20/21 = $10,604,900
d. FFY 21/22 = $2,651,225
For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Time Limited 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 December 31, 2021. 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 ending July 31, 2018; July 31, 2019; July 31, 2020; July 31, 2021; and in the 2021-22 rate year for each patient day on or before December 31, 2021. 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 ending July 31, 2018; July 31, 2019; July 31, 2020; July 31, 2021; and in the 2021-22 rate year for each patient day on or before December 31, 2021, 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 ending July 31, 2018; July 31, 2019; July 31, 2020; July 31, 2021; and in the 2021-22 rate year for each patient day on or before December 31, 2021, 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.