MAR 27 2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

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

Financial Management Group

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: California State Plan Amendment 17-024

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 17-024. This amendment authorizes the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) program for the rate year beginning August 1, 2017.

We conducted our review of your submittal according to the statutory requirements at sections 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 TN 17-024 is approved effective August 1, 2017. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Blake Holt at (415) 744-3754 or Mark Wong at (415) 744-3561.

ORIGINAL SIGNED

Enclosures

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: 17-024

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
August 1, 2017

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:
~~CCR Title 22, Section 51124.5~~ 42 CFR 447 Subparts B and C

7. FEDERAL BUDGET IMPACT:
a. FFY 2016/17 ~~$ 7,500,000~~ $7,333,333
a. FFY 2017/18 ~~$ 37,500,000~~ $36,666,667

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
20a
Supplement 4 to Attachment 4.19-D pages 20, ~~20b~~, 21, 23, 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 4 to Attachment 4.19-D pages 20, 20b, 21, 23, 24

10. SUBJECT OF AMENDMENT:
Extends the Quality and Accountability Supplemental Payment program from to July 31, 2018, adds 30 Day Rehospitalization quality measure, and establishes a system to vary the total amount of supplemental payment awards.

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.

ORIGINAL SIGNED

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
9/25/2017

FOR REGIONAL OFFICE USE ONLY

IX. Quality and Accountability Supplemental Payment

A. For the rate year beginning August 1, 2017, the Department will develop and implement the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) System. This program provides supplemental reimbursement for FS/NF-Bs, including FS/adult subacute facilities, that improve the quality of care rendered to its residents and would be in addition to the rate of payment FS/NF-Bs receive under the current reimbursement methodology.

B. The Department, in consultation with California Department of Public Health (CDPH) and representatives from the long-term care industry; organized labor; and consumers; has developed a three tiered scoring methodology, with improvement scoring, for supplemental payments. The Minimum Data Set data file is obtained from the Centers for Medicare & Medicaid Services (CMS). The Department has a data use agreement with the Health Services Advisory Group for such purposes.

1. 100 points are divided among the measurements with point values distributed for each quality indicator.

Measurement Area/Indicator	Possible Points:
Minimum Data Set Clinical	100.00
Facility Acquired Pressure Ulcer: Long Stay	11.111
Physical Restraints: Long Stay	11.111
Influenza Vaccination: Short Stay	5.55575
Pneumococcal Vaccination: Short Stay	5.55575
Urinary Tract Infection: Long Stay	11.111
Control of Bowel/Bladder: Long Stay	11.111
Self-Report Pain: Short Stay	5.55575
Self-Report Pain: Long Stay	5.55575
Activities of Daily Living: Long Stay	11.111
Direct Care Staff Retention	11.111
30 Day All-Cause Readmission	11.111

2. A facility's score for each indicator is as follows: a facility's performance is less than statewide average: zero points; at or above statewide average, up to but not including 75th percentile: half points; at or above the 75th percentile: full points. Indicators may be added or removed in the future, subject to state and CMS approval.

In determining the statewide average and the 75th percentile for each indicator, the performance of all facilities, including ineligible facilities as defined in paragraph C below, are included.

3. Facilities receive an overall quality of care score when points from each of the quality measures are totaled.

4. Facilities that score at least 50.00 points are eligible for QASP payments.

5. For the clinical quality measures, the prior state fiscal year (July 1 to June 30) performance is used for current rate year payment as well as determination of the 75th percentile and statewide average, except for the staff retention measure. For example, MDS data from the performance period of July 1, 2016 to June 30, 2017 will be used to make rate year 2017/18 payments.

   For the clinical quality measures, CDPH, in collaboration with the Department, computes each facility's score based on the MDS data. In using the MDS data file, the Long Stay Pressure Ulcer measure is adjusted so that unhealed pressure ulcers are not added back into the performance calculation.

   For the direct care staff retention measure, cost reports available from the Office of Statewide Health Planning and Development (OSHPD) for the audit period will be used. The measure will rank facilities based on the amount of direct nursing staff turnover during the reporting period, calculated by dividing "Number of Continuously Employed Direct Nursing Staff During the Report Period" by "Number of Direct Nursing Staff at the Beginning of the Report Period," with less turnover scoring higher.

6. Eligible facilities are grouped into three payment tiers based on their overall quality of care score. Facilities with scores from 0 to 49.99 points are grouped as Tier 1. Facilities with scores from 50.00 to 66.66 points are grouped into Tier 2. And facilities with scores from 66.67 to 100 points are grouped into Tier 3. Ineligible facilities, as defined in paragraph C, are grouped into Tier 0.

   Tier 0 and Tier 1 facilities will not receive any supplemental payments under this QASP program component. The total pool amount for this component is converted into a Tier 2 per diem and a Tier 3 per diem. The Tier 3 per diem is set at 1.5 times the Tier 2 per diem. Each facility within Tier 2 and Tier 3 will receive a supplemental payment equal to the respective tier per diem times the facility's number of Medi-Cal bed days (including Fee-For-Service and managed care days) for the audit period.

The formula for determining the Tier 2 and Tier 3 per diems is as follows:

Total pool = (Aggregate Tier 2 Medi-Cal bed days* x Tier 2 per diem) + (Aggregate Tier 3 Medi-Cal bed days* x 1.5 x Tier 2 per diem)

Tier 3 per diem = Tier 2 per diem x 1.5

* Medi-Cal bed days total for the audit period includes Fee-For-Service and managed care days

The Department will utilize managed care and audited Medi-Cal Fee-For-Service and managed care bed days for determining payment amounts. The audited bed days are drawn from the audit reports used to establish 2017/18 Fee-For-Service per diem rates. Note that any facility that does not have any Medi-Cal Fee-For-Service days from audit period would not be included in the above computation and will not receive this payment.

will receive a supplement payment equal to the improvement per diem times its number of Medi-Cal days (including Fee-For-Service and managed care).

The Medi-Cal days are derived from the same source as Medi-Cal days in paragraph B.6.

Note that any facility that does not have any Medi-Cal Fee-For-Service days in the audit period would not be included in the above computation and will not receive this payment.

8. The aggregate supplemental payment amount for the 2017/18 rate year will be funded by a pool of $88,000,000, of which $2,000,000 will be used to fund the delayed payment pool. Ninety (90) percent of the remaining amount will be used to compute the Tier 2 and 3 per diems in paragraph B.6, and the remaining ten (10) percent will be used to compute the improvement per diem in paragraph B.7. Annually, the pool amounts will be updated in the state plan and will be based on funds derived from the general fund related to setting aside 1% of the weighted average Medi-Cal per diem rate, plus the savings from the Professional Liability Insurance being applied at the 75th percentile and the administrative penalties collected for facilities' failure to meet the nursing hours per patient day requirement, minus administration costs.

9. The delayed payment pool will be used to fund delayed QASP payments which are made after the primary payment, but before June 30, 2019. An example of a delayed payment would be where a facility was originally determined to be ineligible in accordance with paragraph C.a, at the time of primary payment, but such determination was later successfully appealed by the facility within the above timeline. Delayed supplemental or improvement payments will be made on a per diem basis at the respective per diem rate established by the respective rate year calculation. No rate year's per diem calculations will be altered by delayed payments, and no payments originally made to other facilities will be affected by delayed payments. A facility eligible for a delayed payment will receive the established Tier 2 or Tier 3 per diem, based on its own quality of care score. A facility eligible for a delayed payment will receive the established improvement per diem, if its improvement score ranks in the top 20th percentile when included in the ranking of all eligible facilities. Any remaing funds from the delayed payment pool will be applied to the following rate year's aggregate supplemental payments amount. If the amount in the delayed pool is insufficient to pay all computed delayed payments for the current Fiscal Year, additional funds will be made available by deducting from next Fiscal Year's total payment pool so that all facilities eligible for a delayed payment will be paid their computed payments in full.

C. For the rate year beginning on August 1, 2017, the Department will pay an annual lump sum Medi-Cal supplemental payment (as computed in paragraphs B.6 and B.7 above), by April 30, 2018 (and delayed payments by June 30, 2019), to eligible skilled nursing facilities, based on the following performance measures as specified in W&I Code Section 14126.022 (i), as in effect on June 2017:

1. Facility Acquired Pressure Ulcer: Long Stay
2. Physical Restraints: Long Stay
3. Influenza Vaccination: Short Stay
4. Pneumococcal Vaccination: Short Stay
5. Urinary Tract Infection: Long Stay
6. Control of Bowel/Bladder: Long Stay
7. Self-Reported Pain: Short Stay
8. Self-Reported Pain: Long Stay
9. Activities of Daily Living: Long Stay
10. Direct Care Staff Retention
11. 30 Day All-Cause Readmission

a. The Department will determine a facility ineligible to receive supplemental payments if the facility fails to meet the following minimum qualifying criteria:

   i. A facility fails to timely provide supplemental data as requested by the Department.

   ii. CDPH determines that a skilled nursing facility fails to meet the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

   iii. For the performance period, facility has Class AA/A citations. These citations are issued due to serious harm or death of a resident.

   iv. For the audit period, facility does not have any Medi-Cal bed days. Furthermore, facility must have Medi-Cal Fee-For-Service bed days in the payment period in order to receive a Medi-Cal Fee-For-Service supplemental payment.