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State/Territory Name: CA

State Plan Amendment (SPA) #: CA-22-0011

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 & CHIP SERVICES

Financial Management Group

May 3, 2022

Jacey K. Cooper
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 Transmittal Number 22-0011

Dear Ms. Cooper:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 22-0011. This amendment provides for updates to the Skilled Nursing Facility Quality and Accountability Supplement Payment (QASP) for the rate period from January 1, 2022 to December 31, 2022.

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. This is to inform you that Medicaid State plan amendment 22-0011 is approved effective January 1, 2022. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Mark Wong at (415) 744-3561 or mark.wong@cms.hhs.gov.

Sincerely,

[redacted]

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: 22-0011

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2022

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 31,500,000
b. FFY 2023 $ 10,500,000

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

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Extends the Quality and Accountability Supplemental Payment program to December 31, 2022.

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:
  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 3, 2022

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 3, 2022

17. DATE APPROVED: May 3, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL

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 7 and 8 by CMS with state concurrence.

Instructions on Back

IX. Quality and Accountability Supplemental Payment

A. For the rate periods January 1, 2021 through December 31, 2021 and January 1, 2022 through December 31, 2022 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
Physical Restraints: Long Stay	Monitor-only, not scored
Facility Acquired Pressure Ulcer: Long Stay	10.55600
Influenza Vaccination: Short Stay	10.55600
Pneumococcal Vaccination: Short Stay	5.27700
Urinary Tract Infection: Long Stay	5.27700
Control of Bowel/Bladder: Long Stay	10.55600
Self-Report Pain: Short Stay	10.55600
Self-Report Pain: Long Stay	5.27700
Activities of Daily Living: Long Stay	5.27700
California-specific Antipsychotic Medication: Long Stay	10.55600
Direct Care Staff Retention	10.55600
30 Day All-Cause Readmission	10.55600
Infection Preventionist	5
Total	100

2. Except for the infection preventionist measure, 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.

For the infection preventionist measure, facilities will receive a pass/fail score.

If a facility cannot be scored on any measure, as determined by CDPH, they may receive an N/A for that measure.

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.

For the infection preventionist measure, CDPH inspections for compliance with Health and Safety Code section 1255.9, subdivisions (a) and (b), as these subdivisions were effective on January 1, 2022, will be used. If a facility passes all inspections for the infection preventionist measure during the performance period, it will receive the full 5 points for this measure. If a facility does not receive an inspection for this measure during the performance period, it may receive an N/A.

6. Except as provided in subsection (a) of this paragraph, when a facility receives an N/A in any quality measure(s), the points available for the quality measure(s) that receive an N/A will be redistributed across all other quality measures that are scored for that facility.

(a) The infection preventionist measure is limited to a score of 5 points. The infection preventionist measure will not gain points redistributed from other quality measures. However, if a facility receives an N/A in the infection preventionist measure, the 5 points for the infection preventionist measure will be redistributed across all other quality measures that are scored for that facility.

7. 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 audited skilled nursing Medi-Cal Fee-For-Service and managed care bed days for determining payment amounts. For the QASP rate period ending December 31, 2022, the audited skilled nursing bed days are drawn from the audit reports used to establish the calendar year 2022 Fee-For-Service per diem rates. Note that any facility that does not have any Medi-Cal Fee-For-Service days from the 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 rate period of August 1, 2020 – December 31, 2020, and calendar year 2021 will be funded by a pool of $84,000,000, of which $6,000,000 will be used to fund the delayed payment pool. The pool will be divided in the amounts shown below for the applicable payment periods.

Primary Payment Pool Pay By Date (or soon after SPA approval date, if later)	Service Period	Primary Payment Pool	Delayed Payment Pool
4/30/2021	8/1/20 - 6/30/21	$50,500,000	$4,000,000
7/30/2021	7/1/21 - 9/30/21	$13,750,000	$1,000,000
10/31/2021	10/1/21 - 12/31/21	$13,750,000	$1,000,000

The aggregate supplemental payment amount for the rate period of January 1, 2022 through December 31, 2022 will be funded by a pool of $84,000,000, of which $6,000,000 will be used to fund the delayed payment pool. The pool will be divided in the amounts shown below for the applicable payment periods.

Primary Payment Pool Pay By Date (or soon after SPA approval date, if later)	Service Period	Primary Payment Pool	Delayed Payment Pool
4/30/2022 (but no earlier than 4/1/2022)	1/1/22 - 6/30/22	$39,000,000	$3,000,000
9/30/2022 (but no earlier than 7/1/2022)	7/1/22 - 9/30/22	$19,500,000	$1,500,000
12/31/2022 (but no earlier than 10/1/2022)	10/1/22 - 12/31/22	$19,500,000	$1,500,000

Ninety (90) percent of the primary payment pool 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. For the rate periods beginning on or after August 1, 2020, the delayed payment pool for each service period will be available for two years after the first day of the respective service period and will be used to fund delayed QASP payments made after the respective primary lump sum supplemental payment.

C. For the service periods provided in paragraph B.8, the Department will pay a-lump sum Medi-Cal supplemental payment (as computed in paragraphs B.6 and B.7 above), by the respective pay by dates provided in paragraph B.8, (and delayed payments as provided in paragraph B.9), to eligible skilled nursing facilities. These payments will be based on the following performance measures as specified in W&I Code Section 14126.022 (i), as effective on January 1, 2022, and developed by the Department in coordination with CDPH:

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

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 or 1276.65 of the Health and Safety Code, as applicable.

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.