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State/Territory Name: California

State Plan Amendment (SPA) #: 17-004

This file contains the following documents in the order listed:

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

DEC 18 2017

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 17-004

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 17-004. This amendment provides for supplemental payments, funded by a quality assurance fee, for private hospital inpatient services for the service period of January 1, 2017 to June 30, 2019.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 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 17-004 is approved effective January 1, 2017. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

[redacted]

Kristin Fan
Director

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: **17-004**

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
January 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:
42 C.F.R. Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 $1,408,211,383.28
b. FFY 2018 $1,806,299,602.19
c. FFY 2019 $1,366,564,249.18

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Appendix 8 to Attachment 4.19-A
Pages 1-7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None

10. SUBJECT OF AMENDMENT:
Supplemental Payments for Hospital Inpatient Services

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:
Mari Cantwell

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
~~**December 14, 2017**~~ **March 30, 2017**

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: DEC 18 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMCO

23. REMARKS:
Pen-and-ink change made to Box 15 by CMS regional office at request of state on 12/18/2017.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

SUPPLEMENTAL PAYMENTS FOR HOSPITAL INPATIENT SERVICES

This supplemental payment program provides supplemental payments to private hospitals, which meet specified requirements and provide inpatient services to Medi-Cal beneficiaries.

Supplemental payments to hospitals will be up to the aggregate upper payment limit.

Supplemental payments will be made periodically on a lump-sum basis throughout the duration of the program and will not be paid as individual increases to current reimbursement rates for specific services. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals.

The supplemental payment program will be in effect from January 1, 2017 through June 30, 2019.

A. Amendment Scope and Authority

This amendment, Appendix 8 to Attachment 4.19-A, describes the payment methodology to provide supplemental payments to eligible hospitals between January 1, 2017 through June 30, 2019. Supplemental payments will be made on a quarterly basis, with a lump sum payment of quarterly payments for quarters prior to the approval date of the SPA.

B. Eligible Hospitals

1. Hospitals eligible for supplemental payments under this Appendix are "private hospitals," which means a hospital that meets all of the following conditions:

    a. Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

    b. Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2013.

    c. Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

d. Is a nonpublic hospital, nonpublic converted hospital, or converted hospital (Public to Private), as those terms were defined on January 1, 2017, in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98 of the California Welfare and Institutions Code.

2. A hospital that is eligible pursuant to Paragraph 1 for supplemental payments under this Appendix will become ineligible if any of the following occur:

   a. The hospital becomes a Private to Public Converted Hospital pursuant to Paragraph 1 of Section C.

   b. The hospital is a new hospital as defined in Paragraph 2 of Section C.

   c. The hospital does not meet with all the requirements as set forth in Paragraph 1.

   d. The period for which hospital is deemed closed pursuant to Welfare and Institutions Code section 14169.61(c) as the law was in effect on January 1, 2017.

   e. The hospital does not have any Medi-Cal fee-for-service inpatient hospital utilization for the service period.

C. Definitions

For purposes of this attachment, the following definitions apply:

1. "Private to Public Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after January 1, 2017.

2. "New hospital" means a hospital operation, business or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary obligation owed to the state in connection with the Medi-Cal program and the hospital is not, or does not agree to become, financially responsible to the department for the outstanding monetary obligation. "New hospital" does not include a hospital described in Welfare and Institutions Code section 14169.59, subdivision (g)(5), as that section reads as of January 1, 2017, and for such a hospital, the number of Medi-Cal patient days used in paragraph D will be determined in a manner consistent with how the hospital is accounted for in the private hospital upper payment limit demonstration - that is, the number of Medi-Cal days will be derived from an average of proxy hospitals' Medi-Cal patient days, and adjusted for bed size difference and for any applicable period of closure or non-operation.

3. "Acute psychiatric days" means the total number of Medi-Cal specialty mental health service administrative days, Medi-Cal specialty mental health service acute care days, acute psychiatric administrative days and acute psychiatric acute days for the 2013 calendar year as calculated by the department on December 17, 2016 and were paid directly by the department and were not the financial responsibility of a mental health plan.

4. "General acute care days" means the total number of Medi-Cal general acute care days, including well baby days, less any acute psychiatric inpatient days, paid by the department to a hospital for services in the 2013 calendar year, as reflected in the state paid claims file on December 28, 2016.

5. "High acuity days" means Medi-Cal coronary care unit days, pediatric intensive care unit days, intensive care unit days, neonatal intensive care unit days, and burn unit days paid by the department to a hospital for services in the 2013 calendar year, as reflected in the state paid claims file prepared by the department on the December 28, 2016.

6. "Program period" means the time period from January 1, 2017, through June 30, 2019, inclusive.

7. "Days data source" means either: (1) if a hospital's Annual Financial Disclosure Report for its fiscal year ending in the base calendar year includes data for a full fiscal year of operation, the hospital's Annual Financial Disclosure Report retrieved from the Office of Statewide Health Planning and Development as retrieved by the department on December 20, 2016 pursuant to Section 14169.59, for its fiscal year ending in the base calendar year; or (2) if a hospital's Annual Financial Disclosure Report for its fiscal year ending in the base calendar year includes data for more than one day, but less than a full year of operation, the department's best and reasonable estimates of the hospital's Annual Financial Disclosure Report if the hospital had operated for a full year.

8. "Subject fiscal year" means state fiscal years 2016-17, 2017-18 and 2018-19.

9. "Hospital inpatient services" means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services do not include professional services or services for which a managed health care plan is financially responsible.

10. "Service period" means the quarter to which the supplemental payment is applied.

11. "Subacute supplemental payment" means a fixed proportional supplemental payment for acute inpatient services based on a hospital's prior provision of Medi-Cal subacute services.

12. "Medicaid Inpatient Utilization Rate" means the final Medicaid utilization statistics computed for the 2015-16 state fiscal year for disproportionate share hospital payment purposes, as reflected in the state paid claims file based on calendar year 2013 data and calculated by the department as of December 17, 2016. The Department may correct any identified material and egregious errors in the data.

D. Supplemental Payment Methodology for Private Hospitals

1. Private hospitals will be paid supplemental amounts for the provision of hospital inpatient services for the program period. The supplemental amounts will be in addition to any other amounts payable to hospitals with respect to those services and will not affect any other payments to hospitals.

2. Private hospitals will be paid from the total amount of seven billion, seven hundred forty-seven million, five hundred one thousand, eight hundred fifty-seven and five cents ($7,747,501,857.05), consisting of the following subpools:

   General Acute Subpool: $6,029,853,353.53
   Psychiatric Subpool: $107,374,276.06
   High Acuity Subpool: $882,462,103.72
   High Acuity Trauma Subpool: $288,206,250.00
   Subacute Subpool: $387,549,623.75
   Transplant Subpool: $52,056,250.00

   Each private hospital will be paid the following amounts as applicable for the provision of hospital inpatient services for each subject fiscal year:

   a. From the general acute subpool:

   - For the last two subject fiscal quarters of the subject fiscal year 2016-17, one thousand, six hundred thirty-two dollars and fifteen cents ($1,632.15) multiplied by half of the hospital's annual general acute care days.

   - For the subject fiscal year 2017-18, one thousand, five hundred forty dollars and sixty-three cents ($1,540.63) multiplied by the hospital's general acute care days.

   - For the subject fiscal year 2018-19, one thousand, five hundred seventy dollars and seventy-nine cents ($1,570.79) multiplied by the hospital's general acute days.

b. From the psychiatric subpool, for a hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan:

- For the last two subject fiscal quarters of the subject fiscal year 2016-17, nine hundred and seventy-five dollars ($975.00) multiplied by half of the hospital's annual covered acute psychiatric days.

- For the subject fiscal years 2017-18 and 2018-19, nine hundred and seventy-five dollars ($975.00) multiplied by the hospital's acute psychiatric days.

c. From the high acuity subpool, in addition to the amount specified in Subparagraphs a and b, if a private hospital that provided Medi-Cal high acuity services during 2013 calendar year and has Medicaid inpatient utilization rate that is greater than 5 percent and less than 41.6 percent:

- For the last two subject fiscal quarter quarters of the subject fiscal year 2016-17, two thousand five hundred dollars ($2,500.00) will be multiplied by half of the hospital's annual high acuity days.

- For the subject fiscal years 2017-18 and 2018-19, two thousand five hundred dollars ($2,500.00) multiplied by the number of the hospital's high acuity days.

d. From the high acuity trauma subpool, in addition to the amounts specified in Subparagraphs a, b and c, if the hospital qualifies to receive the amount set forth in Paragraph c and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code, as the section read on January 1, 2017:

- For the last two subject fiscal quarters of the subject fiscal year 2016-17, two thousand five hundred dollars ($2,500.00) will be multiplied by half of the hospital's annual high acuity days.

- For the subject fiscal years 2017-18 and 2018-19, two thousand five hundred dollars ($2,500.00) multiplied by the number of the hospital's high acuity days.

e. From the subacute subpool, if a private hospital that provided Medi-Cal subacute services during the 2013 calendar year and has a Medicaid inpatient utilization rate that is greater than 5 percent and less than 41.6 percent:

- The subacute supplemental rate shall be 30 percent (half of 60 percent) for the two remaining subject fiscal quarters in the subject fiscal year 2016-17, 60 percent for the subject fiscal quarters in the subject fiscal year 2017-18, 60 percent for the subject fiscal quarters in the subject fiscal year 2018-19 of the Medi-Cal subacute payments paid by the department to the hospital for services during the 2013 calendar year, as reflected in the state paid claims file prepared by the department on December 28, 2016.

f. From the transplant subpool, in addition to Subparagraphs a, b, c, d, and e, a private hospital that has Medi-Cal days for Medicare Severity-Diagnosis Related Groups 1, 2, 5 to 10, inclusive, 14, 15, and 652, according to the Patient Discharge file from the Office of Statewide Health Planning and Development for the 2013 calendar year assessed on December 27, 2016:

- For the last two fiscal quarters of the subject fiscal year 2016-17, two thousand five hundred dollars ($2,500.00) will be multiplied by half of the hospital's annual Medi-Cal days for Medicare Severity-Diagnosis Related Groups identified above.

- For the subject fiscal years 2017-18 and 2018-19, two thousand five hundred dollars ($2,500.00) multiplied by the number of Medi-Cal days.

g. The amounts computed above for subject fiscal year 2016-17 are divided by two to arrive at the quarterly payment amount for the two quarters in subject fiscal year 2016-17. The amounts computed above for each subject fiscal years 2017-18 and 2018-19 are divided by four to arrive at the quarterly payment amounts for the four quarters in each of the subject fiscal years 2017-18 and 2018-19

3. In the event that payment of all of the amounts for the program period from any subpool in Paragraph 2 would cause total payments for the program period from that subpool to exceed the amount specified above for that subpool, the payment amounts for each hospital from the subpool will be reduced pro rata so that the total amount of all payments from that subpool does not exceed the subpool amount.

4. In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to private hospitals under Paragraph 2 due to the application of an upper payment limit, which is subject to annual submission and review, or for any other reason, the following will apply:

   a. The total amounts payable to private hospitals under Paragraph 2 for each subject service period within the fiscal year will be reduced to reflect the amounts for which federal financial participation is available pursuant to subparagraph b.

b. The amounts payable under Paragraph 2 to each private hospital for each subject service period within the fiscal year will be equal to the amounts computed under Paragraph 2 multiplied by the ratio of the total amounts for which federal financial participation is available to the total amounts computed under Paragraph 2.

c. In the event that a hospital's payments in any fiscal year as calculated under Paragraph 2 are reduced by the application of this Paragraph 4, the amount of the reduction will be added to the supplemental payments for the next subject fiscal year within the program period, which the hospital would otherwise be entitled to receive under Paragraph 2, provided further that no such carryover payments will be carried over beyond the period ending June 30, 2019, and such carryover payments will not result in total payments exceeding the applicable federal upper payment limit for the fiscal year.

5. The payment amounts set forth in this Appendix are inclusive of federal financial participation.

6. Payments shall be made to a hospital that becomes ineligible pursuant to Paragraph 2 of Section B during a subject fiscal quarter by multiplying the hospital's inpatient supplemental payment by the number of days that the hospital was eligible in the subject fiscal quarter, divided by the number of days in the subject fiscal quarter. Payments shall not be made to an ineligible hospital in any subsequent subject fiscal quarter.

7. Payments shall be made to a converted hospital (Private to Public) which converts during a subject fiscal quarter by multiplying the hospital's inpatient supplemental payment by the number of days that the hospital was a private hospital in the subject fiscal quarter, divided by the number of days in the subject fiscal quarter. Payments shall not be made to a converted hospital (Private to Public) in any subsequent subject fiscal quarter.