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State/Territory Name: California

State Plan Amendment (SPA) #: 18-013

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

JUN 19 2018

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 18-013

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 18-013. This amendment, effective July 1, 2018, updates California's All Patient Refined Diagnosis Related Group (APR-DRG) payment parameters for state fiscal year 2018-2019.

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 18-013 is approved effective July 1, 2018. 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: **18-013**

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
July 1, 2018

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 CFR Part 447, Subpart C. 1902(a)(13) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $0
b. FFY 2019 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A pages 17.41- 17.42, 17.48, 17.49, 17.62

Appendix 6 to Attachment 4.19A, pages 1-3

Attachment 4.19-A pages 29, 29a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A pages 17.41- 17.42, 17.48, 17.49, 17.62

Attachment 4.19-A pages 29, 29a

Appendix 6 to Attachment 4.19A, pages 1-3

10. SUBJECT OF AMENDMENT:

Inpatient Hospital APR-DRG updates for SFY 2018-19

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:
June 12, 2018

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: JUN 19 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL:

[redacted]

21. TYPED NAME:

22. TITLE: Director, FMG

23. REMARKS:

Pen-and-ink changes made to Boxes 8 and 9 by CMS regional office with state concurrence on 6/18/2018.

FORM HCFA-179 (07-92)

miles in driving distance from the nearest GAC hospital that has a basic level emergency room, and does not operate under a combined license or bill under a common National Provider Index (NPI) number with a non-remote rural hospital.

19. "Remote Rural Border Hospital" is a border hospital that is defined as a rural hospital by the federal Medicare program, is at least fifteen (15) miles in driving distance from the nearest GAC hospital that has a basic level emergency room, and does not operate under a combined license or bill under a common National Provider Index (NPI) number with a non-remote rural hospital.
20. "State Fiscal Year" (SFY) is California state government's fiscal year which begins on July 1 and ends the following June 30.
21. "Hospital-Specific Wage Area Index Values" are hospital-specific geographic adjustments that Medicare uses (from the Medicare hospital impact file) further adjusted by the California Wage Area Neutrality Adjustment of 0.9771 for California hospitals.

B. Applicability

1. Except as specified below in Paragraph 2, for admissions dated July 1, 2013 for private hospitals, and after and commencing on admissions dated January 1, 2014, and after for NDPHs, the Department of Health Care Services (DHCS) will reimburse "DRG Hospitals" through a prospective payment methodology based upon APR-DRG.
2. The following are "Exempt Hospitals, Services, and Claims" that are not to be reimbursed based upon APR-DRG:
   a. Psychiatric hospitals and psychiatric units
   b. Rehabilitation hospitals, rehabilitation units, and rehabilitation stays at general acute care hospitals
   c. Designated Public Hospitals
   d. Indian Health Services Hospitals
   e. Inpatient Hospice
   f. Swing-bed stays
   g. Managed Care stays

h. Administrative Day Reimbursement claims
   i. Level I
   ii. Level 2

C. APR-DRG Reimbursement

For admissions dated July 1, 2013, and after for private hospitals and for admissions dated January 1, 2014, and after for NDPHs, reimbursement to DRG Hospitals for services provided to Medi-Cal beneficiaries are based on APR-DRG. Effective July 1, 2015, APR-DRG Payment is determined by multiplying a specific APR-DRG HSRV by a DRG Hospital's specific APR-DRG Base Price with the application of adjustors and add-on payments, as applicable. Provided all pre-payment review requirements have been approved by DHCS, APR-DRG Payment is for each admit through discharge claim, unless otherwise specified in this segment of Attachment 4.19-A.

1. APR-DRG HSRV

The assigned APR-DRG code is determined from the information contained on a DRG Hospital's submitted UB-04 or 837I acute inpatient claim. The grouping algorithm utilizes the diagnoses codes, procedure codes, procedure dates, admit date, discharge date, patient birthdate, patient age, patient gender, and discharge status present on the submitted claim to group the claim to one of 326 specific APR-DRG-groups. Within each specific group of 326, there are four severities of illness and risk of mortality sub classes: minor (1), moderate (2), major (3), and extreme (4). This equates to a total of 1304 different APR DRG (with two additional error code possibilities). Each discharge claim is assigned only one APR-DRG code. For each of the 1304 APR-DRG codes there is a specific APR-DRG HSRV assigned to it by the APR-DRG grouping algorithm. The APR-DRG HSRVs are

receive a percentage increase that would result in a transitional base price above the statewide base price.

k. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY2013-14 were sent to private hospitals January 30, 2013.

l. The DRG Hospital Specific Transitional APR-DRG Base Price forSFY2013-14 were sent to NDPHs June 17,2013.

m. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2014-15 and SFY 2015-16 was provided to hospitals on July 31, 2013. Transitional APR-DRG

Base Prices are subject to change based on changes to the Medicare Wage Index, hospital characteristics or other reasons. The updated DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2015-16 were sent to private hospitals and NDPHs on May 29, 2015, June 2, 2015, and June 3, 2015.

2. DRG Hospital Specific APR-DRG Base Prices for SFY 2016-17 and for subsequent SFY.

The DRG Hospital Specific Transitional APR-DRG Base Price ceased starting SFY 2016-17. DRG payment rates no longer receive transition based adjustments to the DRG payment rate. All hospitals received the statewide base price in SFY 2016-17 and will continue to receive the statewide base price in subsequent SFY.

3. Wage Area Adjustor

a. Hospital-Specific Wage Area Index values will be used to adjust the APR-DRG Base Price for DRG Hospitals and Border Hospitals. The Hospital-Specific Wage Area Index Value for a California hospital or Border hospital shall be the same hospital specific wage area index value that the Medicare program applies to that hospital, further adjusted by the California Wage Area Neutrality Adjustment of 0.9771. In determining the hospital-specific wage area index values for each SFY, DHCS will utilize data from the latest Medicare Impact file published prior to the start of the state fiscal year, including wage area boundaries, any reclassifications of hospitals into wage index areas, wage area index values, and any other wage area or index value adjustments that are used by Medicare Out of state hospitals that are not Border hospitals will receive a wage area adjustor of 1.00. The wage area adjustor is applied to the labor share percentage, as specified in Appendix 6, of the statewide base price or

the remote rural base price. The labor share percentage for a SFY shall be the same percentage that the Medicare program has established according to the latest published CMS final rule and notice published prior to the start of the state fiscal year, with the exception for hospitals having wage area index less than or equal to 1.00 will have the labor share percentage applied at 62.0%. Medicare published the Medicare impact file for FFY 2018 in September 2017 and it was used for the base prices for SFY 2018-19.

Similarly, final changes to all DRG hospitals wage area, index value, or labor share calculation published for future federal fiscal years will be used for the state fiscal year beginning after the start of each respective federal fiscal year. All wage area index values can be viewed on the Medi-Cal DRG Pricing Calculator posted on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

b. The wage area adjustor is not applied to the hospital-specific transitional base price (determined in paragraph C.3 above).

4. Policy Adjustors

The implementation of APR-DRG Payment includes the functionality of policy adjustors. These adjustors are created to allow the DHCS to address any current, or future, policy goals and to ensure access to care is preserved. Policy adjustors may be used to enhance payment for services where Medi-Cal plays a major role. This functionality of policy adjustors allows DHCS the ability to ensure access to quality care is available for all services. A list of the current policy adjustors is reflected in Appendix 6 of Attachment 4.19-A. These policy adjustors are multipliers used to adjust payment weights for care categories. If an inpatient stay qualifies for more than one policy adjustor, the payment weight will be accordingly adjusted by all applicable multipliers. The projected financial impact of the policy adjustors was considered in developing budget-neutral base prices.

5. Cost Outlier Payments

Outlier payments are determined by calculating the DRG Hospital's estimated cost and comparing it to the APR-DRG Payment to see if there is a loss or gain for the hospital for a discharge claim. The DRG Hospital's estimated cost on a discharge claim is determined by the following: The DRG Hospital's estimated cost may be determined by multiplying the Medi-Cal covered charges by the DRG Hospital's most currently accepted cost-to-charge ratio (CCR) from a hospital's CMS 2552-10 cost report. The CCR is calculated from a hospital's Medicaid costs (reported on worksheet E-3, part VII, line 4) divided by the Medicaid charges (reported on worksheet E-3, part VII, line 12). All hospital CCRs will be updated annually with an effective date of July 1, after the acceptance of the CMS 2552-10 by DHCS. In alternative, a hospital (other than a new hospital or an out-of-state border or

Provided all requirements for prepayment review have been approved by DHCS, Rehabilitation Services are paid a per diem amount for each day of service that is authorized, unless otherwise specified in Attachment 4.19-A. The specific per diem rates for pediatric and adult rehabilitation services are specified in Appendix 6 and are statewide rates. The specific pediatric and adult rehabilitation per diem rates were set at a level that is budget neutral on a statewide basis for both adult and pediatric rehabilitation services based on rates in effect June 30, 2013. The specific per diem rate for a hospital that provided services to both the adult and pediatric population is based on the blend of pediatric and adult rehabilitation services provided at that specific hospital. A facility-specific blended rate is the weighted average of the statewide adult and statewide pediatric per diem rates, weighted by the individual facility's number of adult and pediatric rehabilitation days in the base period used to determine the statewide per diem rates. The labor portion of all rehabilitation rates are further adjusted by the Medicare Wage Index value for each specific hospital. The labor portion is specified in Appendix 6.

E. Updating Parameters

DHCS will review and update the Rehabilitation Services payment parameters through the State Plan Amendment process. When reviewing and updating, DHCS shall consider: access to care related to Rehabilitation Services provided at a DRG Hospital, and any other issues warranting review.

F. Pre-Payment and Post Payment Review

All claims paid under the rehabilitation per diem are subject to DHCS' pre-payment medical necessity review and discretionary post-payment review.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Appendix 6

1. APR-DRG Payment Parameters

Parameter	Value	Description
Remote Rural APR-DRG Base Price	$12,832	Statewide Remote Rural APR-DRG Base Price
Statewide APR-DRG Base Price	$6,507	Statewide APR-DRG Base Price (non-Remote Rural)
Policy Adjustor - Age	1.25	Policy Adjustor for claims whose patients are less than 21 years old with a DRG in the 'miscellaneous pediatric' or 'respiratory pediatric' care categories.
Policy Adjustor – NICU services	1.25	Policy Adjustor for all NICU DRGs (i.e. DRGs assigned to the 'neonate' care category, except for those receiving the NICU Surgery policy adjuster below).
Policy Adjustor – NICU surgery	1.75	Enhanced Policy Adjustor for all designated NICU facilities and surgery sites recognized by California Children's Services (CCS) Program to perform neonatal surgery. For all DRGs assigned to the neonate care category
Policy Adjustor- Obstetrics	1.06	Policy adjustor value for obstetric care
Policy Adjustor-Severity of Illness (SOI) 4-Age and NICU	1.40	Policy Adjustor for a DRG with SOI 4 in the 'miscellaneous pediatric' or 'respiratory pediatric', or 'neonate' care category.
Policy Adjustor-SOI 4-Adult	1.10	Policy Adjustor for a DRG with SOI 4 in the 'miscellaneous adult' or 'respiratory adult' or 'gastroenterology adult' or 'circulatory adult'.
Policy Adjustor-SOI 4-Obstetrics	1.10	Policy Adjustor for a DRG with SOI 4 in the 'obstetrics' care category.
Policy Adjustor – Each other category of service	1.00	Policy adjustor for each other category of service.
Wage Index Labor Percentage	68.3%	Percentage of DRG Base Price or Rehabilitation per diem rate adjusted by the wage index value.
High Cost Outlier Threshold	$57,000	Used to determine Cost Outlier payments
Low Cost Outlier Threshold	$57,000	Used to determine Cost Outlier payments
Marginal Cost Factor	60%	Used to determine Cost Outlier payments

Parameter	Value	Description
Discharge Status Value 02	02	Transfer to a short-term general hospital for inpatient care
Discharge Status Value 05	05	Transfer to a designated cancer center
Discharge Status Value 63	63	Transfer to a long-term care hospital
Discharge Status Value 65	65	Transfer to a psychiatric hospital
Discharge Status Value 66	66	Transfer to a critical access hospital (CAH)
Discharge Status Value 82	82	Transfer to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
Discharge Status Value 85	85	Transfer to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
Discharge Status Value 91	91	Transfer to a Medicare certified Long Term Care Hospital with a planned acute care hospital inpatient readmission
Discharge Status Value 93	93	Transfer to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
Discharge Status Value 94	94	Transfer to a Critical Access Hospital with a planned acute care hospital inpatient readmission
Interim Payment	$600	Per diem amount for Interim Claims
APR-DRG Grouper Version	V.35	3M Software version used to group claims to a DRG
HAC Utility Version	V.35	3M Software version of the Healthcare Acquired Conditions Utility
Pediatric Rehabilitation Rate	$1,841	Daily rate for rehabilitation services provided to a beneficiary under 21 years of age on admission.
Adult Rehabilitation Rate	$1,032	Daily rate for rehabilitation services provided to a beneficiary 21 years of age or older on admission.

2. Separately Payable Services, Devices, and Supplies

Code	Description
	Bone Marrow
38204	Management of recipient hematopoietic progenitor cell donor search and acquisition
38204	Unrelated bone marrow donor
	Blood Factors
J7180	Blood factor XIII
J7183/J7184/Q2041	Blood factor Von Willebrand –injection
J7185/J7190/J7192	Blood factor VIII
J7186	Blood factor VIII/ Von Willebrand
J7187	Blood factor Von Willebrand
J7189	Blood factor VIIa

Code	Description
J7193/J7194/J7195	Blood factor IX
J7197	Blood factor Anti-thrombin III
J7198	Blood factor Anti-inhibitor
C9134	Blood Factor XIII Antihemophilic factor
J7199	Alprolix and Factor VIII
	Long Acting Reversible Contraception Methods
J7300	Intrauterine Copper (Paraguard)
J7301	Skyla
J7302	Levonorgestral-releasing intrauterine contraceptive system (Mirena)
J7307	Etonogestrel (Implanon, Nexplanon)

3. **List of Hospitals Eligible to receive the "DRG- NICU- Surgery Policy Adjustor"**

   A. Hospitals approved to receive Policy Adjustor – NICU Surgery, status as of May 12, 2018:

   1) California Pacific Medical Center - Pacific
   2) Cedars Sinai Medical Center
   3) Children's Hospital & Research Center of Oakland (UCSF Benioff Oakland)
   4) Children's Hospital of Central California
   5) Children's Hospital of Los Angeles
   6) Children's Hospital of Orange County
   7) Citrus Valley Medical Central – Queen of the Valley
   8) Community Regional Medical Center Fresno
   9) Good Samaritan - San Jose
   10) Huntington Memorial Hospital
   11) Kaiser Anaheim
   12) Kaiser Downey
   13) Kaiser Fontana
   14) Kaiser Foundation Hospital - Los Angeles
   15) Kaiser Permanente Medical Center - Oakland
   16) Kaiser Foundation Hospital – Roseville
   17) Kaiser Permanente – Santa Clara
   18) Kaiser Foundation Hospital San Diego
   19) Loma Linda University Medical Center
   20) Lucille Salter Packard Children's Hospital – Stanford
   21) Miller Children's at Long Beach Memorial Medical Center
   22) Pomona Valley Hospital Medical Center
   23) Rady Children's Hospital - San Diego
   24) Santa Barbara Cottage Hospital
   25) Sutter Memorial Hospital

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

PRIVATE DISPROPORTIONATE SHARE HOSPITAL REPLACEMENT SUPPLEMENTAL PAYMENTS

and LIUR data used to determine a hospital's eligibility status. "Final DSH list" means a finalized list of hospitals determined DSH eligible, after any necessary corrections or adjustments are made to the eligibility data.

b. The Department shall make the first interim payment for a project year to each eligible private hospital no later than 60 days after the issuance of the tentative DSH list for the project year and shall include the interim payment amount for all prior months in the project year. These monthly interim payments will be made no earlier than the quarter ending December 31 of each project year.

2. Tentative adjusted monthly payments shall be made for the months of December through March of each project year to each eligible private hospital identified on the final DSH list for the project year and paid as follows:

   a. The Department shall compute an adjusted payment amount for each eligible private hospital in accordance with Attachment 4.19-A, Appendix 2, page 29ffff, paragraph P.

   b. The Department shall compute a tentative adjusted monthly payment amount for each eligible private hospital. The amount shall be equal to the adjusted payment amount for the hospital minus the aggregate interim payments made to the hospital for the project year divided by seven.

   c. The Department will make the first tentative adjusted monthly payment for a project year to each eligible private hospital by January 15, or within 60 days after the issuance of the final DSH list for a project year, whichever of these dates is later. This payment amount shall include the tentative adjusted monthly payment amounts for all prior months in the project year for which those payments are due. These monthly tentative adjusted payments will be made no earlier than the quarter ending March 31 of each project year.

3. Final adjusted total payments shall be paid to each private hospital identified on the final DSH list in the following manner:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

SUPPLEMENTAL REIMBURSEMENT FOR QUALIFIED PRIVATE HOSPITALS

a. Eligible private hospitals identified on the final DSH list for the project year shall receive three final adjusted payment amounts for the months of April through June of the project year. These payments shall be computed and paid as follows:

   i. The Department shall compute an annual final data adjusted payment amount for each eligible hospital in accordance with paragraph P of Appendix 2 to this Attachment 4.19-A (entitled the "prior DSH methodology"). This payment amount shall reflect data corrections, hospital closures and any other revisions made by the Department after the issuance of the tentative adjusted monthly payments.

   ii. The Department shall compute a monthly final data adjusted payment amount for each eligible private hospital. This amount shall be equal to the annual final data adjusted payment amount for the hospital minus both the aggregate interim payments made to the hospital for the project year and the aggregate tentative adjusted monthly payments made to the hospital divided by three. These monthly final data adjusted payments will be made no earlier than the quarter ending June 30 of each project year.

4.

The Department will complete the above payments, which are based on preliminary FY federal Disproportionate Share Hospital allotments issued by CMS, to all eligible private hospitals by June 30 of the next project year. After CMS releases the final FY federal Disproportionate Share Hospital allotment, the Department will recalculate as needed to determine recoupment or additional payments. Additional payments will be made within 90 days of the CMS release of the final FY federal Disproportionate Share Hospital allotment.