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State/Territory Name: CA

State Plan Amendment (SPA) #: CA-22-0028

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

June 28, 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 22-0028

Dear Ms. Cooper:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 22-0028. Effective June 30, 2022, this amendment provides for updates to the description of the hospital-specific disproportionate share hospital (DSH) limit to take into consideration Section 203 of the Consolidated Appropriations Act (CAA) of 2021. This amendment also provides for additional technical updates within the DSH state plan methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 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 22-0028 is approved effective June 30, 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: 22-0028

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

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

4. PROPOSED EFFECTIVE DATE
~~July 1, 2022~~ June 30, 2022

5. FEDERAL STATUTE/REGULATION CITATION
Section 1923(g) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, pages 20, ~~24-27a~~ 24, 25, 26, 27, and 28

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, pages 20, ~~24-27a~~ 24, 25, 26, 27, and 28

9. SUBJECT OF AMENDMENT
Disproportionate Share Hospital (DSH) Medicaid Shortfall Adjustments due to CAA 2021 and Other Technical Adjustments

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:
Please note: 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
May 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
May 3, 2022

17. DATE APPROVED
June 28, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
June 30, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

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 4, 7 and 8 by CMS with state concurrence.

Instructions on Back

4. "Government-operated hospital" means a hospital that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

5. "High DSH facility" or "high DSH status" means a government-operated hospital that is an eligible hospital that meets the criteria set forth in paragraph A.I.a or A.l.b, pursuant to Section I396r-4(g)(2)(B) of Title 42 of the United States Code and Section 4721(e) of the Balanced Budget Act of 1997 (P.L. No. 105-33), as amended by Section 607(a)(3) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into the Omnibus Consolidated Appropriations Act, 2000 (P.L. No. 106-112).

6. "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the California Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

7. "Payment adjustment" or "payment adjustment amount" means an amount paid or payable pursuant to Sections D through F, below, for acute inpatient hospital services provided by an eligible disproportionate share hospital.

8. "Payment adjustment year" means the state fiscal year (commencing July 1) with respect to which payment adjustments are to be made to eligible hospitals.

9. "Applicable federal fiscal year" means the federal fiscal year that commences on October 1 of the particular, or subject, payment adjustment year.

10. "Federal DSH allotment" means the maximum allotment of federal financial participation for DSH payment adjustments for California, as determined under Section 1396r-4(f) of Title 42 of the United States Code, for the applicable federal fiscal year.

11. "Finalized Medi-Cal 2552-10 cost report" means the cost report that is settled by the California Department of Health Services, Audits and Investigations (A&I) with the issuance of a Report on the Cost Report Review (Audit Report).

12. "Filed Medi-Cal 2552-10 cost report" means the cost report that is submitted by the hospital to A&I and is due five months after the end of the cost reporting period.

13. "OBRA 1993 limit" means the hospital-specific limitation on the total annual amount of DSH payment adjustments to each eligible hospital that can be made with federal financial participation under the provisions of Section l 396r-4(g) of Title 42 of the United States Code, as implemented pursuant to Section F, below.

affect the total amount available for distribution. Amounts distributed to the hospitals pursuant to this subparagraph will not be used for determining compliance with the OBRA 1993 DSH limit; the OBRA 1993 DSH limit for each hospital will be determined in accordance with subparagraph D.2.b(2), above.

3. The federal DSH allotment will be applied with respect to the payment adjustments that are made for the subject payment adjustment year as described in subsections D.1 and D.2. For purposes of determining compliance with the federal DSH allotment, the costs incurred during the state fiscal year that are used to establish the cost-based DSH claims will be deemed to be payment adjustments for the period October 1 through June 30 of the applicable federal fiscal year.

E. Methodology for Determining Hospital Uncompensated Care Costs

Each eligible hospital's Medi-Cal 2552-10 cost report will be the basis for determining the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs. The determinations will be used for purposes of establishing and applying the OBRA 1993 limit described in Section F, below, and, with respect to cost-based DSH facilities, for purposes of establishing the cost based DSH claims that will be made by the State.

1. Interim Determination of Uncompensated Care Costs

a. Using the hospital's most recently filed Medi-Cal 2552-10 cost report and auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges), the cost report apportionment process as prescribed in the Worksheet D series will be applied to compute the hospital's interim uncompensated care costs. This data will be submitted to the State. The data must be from the period which corresponds to the most recently filed Medi-Cal cost report.

b. Los Angeles County hospitals (to the extent that they, as all-inclusive-charge-structure hospitals, have been approved by Medicare to use alternative statistics, such as relative value units, in the cost report apportionment process) may also use alternative statistics as a substitute for charges in all of the apportionment processes described in this Section E. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

c. On the Medi-Cal 2552-10 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26. If the costs have been removed, the allowable interns and residents costs will be added back to each affected cost center prior to the

computation of cost-to-charge ratios on Worksheet C. This can be accomplished by using Worksheet B, Part I, column 25 (instead of column 27) for the Worksheet C computation of cost-to-charge ratios. Only those allowable interns and residents costs that are consistent with Medicare cost principles will be added back. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as Graduate Medical Education (GME) under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

d. For hospitals that remove inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), necessary adjustments will be made to the Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-10 worksheets) to account for inpatient dental services. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

e. All applicable Medicaid inpatient and outpatient hospital revenues, and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed inpatient and outpatient hospital cost above to arrive at the hospital's total interim uncompensated care costs (except as otherwise provided in section F.1.c below). Payments, funding and subsidies made by a state or a unit of local government will not be offset (e.g., state-only, local-only or state- local health programs). The revenue and payment data will relate to services rendered during the period that corresponds to that of the Medi-Cal cost report upon which the inpatient and outpatient hospital cost determination is based.

f. The interim uncompensated care costs computed above will be trended to current year based on Market Basket update factor(s) or other approved hospital-related indices as approved by CMS. The interim uncompensated care costs may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1) Inpatient and outpatient hospital costs not reflected on the filed Medi-Cal 2552-10 cost report from which the interim uncompensated care costs are developed, but which would be incurred and reflected on the Medi-Cal 2552-10 cost report for the current year.

(2) Inpatient and outpatient hospital costs incurred and reflected in the filed Medi-Cal 2552-10 cost report from which the interim uncompensated care costs are developed, but which would not be

incurred or reflected on the Medi-Cal 2552-10 cost report for the current year.

Such costs must be properly documented by the hospital, and are subject to review by the State and CMS.

g. The interim uncompensated care costs determined under this subsection E.1 will not include any of the hospital's expenditures for which demonstration funding is or will be claimed for the provision of inpatient hospital and outpatient hospital services to uninsured patients for the subject payment adjustment year. Accordingly, the uncompensated care costs that are used to claim demonstration funding will be considered Medicaid revenue for purposes of subsection E.l, but the payment amounts actually received by the hospitals will not.

h. The State may apply an audit factor to the filed Medi-Cal 2552-10 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-10 cost reporting periods for which final determinations have been made. The State will identify such percentage to CMS.

2. Interim Reconciliation of Uncompensated Care Costs

a. Each eligible hospital's interim uncompensated care costs will be reconciled based on its filed Medi-Cal 2552-10 cost report for the subject payment adjustment year.

b. The hospital's total uncompensated care costs shall be determined using the filed Medi-Cal 2552-10 cost report and applying the steps set forth in paragraphs E.l.a through E.1.e, and paragraphs E.1.g. and E.1.h, above.

3. Final Reconciliation of Uncompensated Care Costs

a. Each eligible hospital's interim uncompensated care costs (and any interim adjustments) will be reconciled based on its finalized Medi-Cal 2552-10 cost report for the subject payment adjustment year.

b. The hospital's total uncompensated care costs shall be determined using the finalized Medi-Cal 2552-10 cost report and applying the steps set forth in paragraphs E.1.a through E.l.e, and paragraph E.1.g., above.

F. Computation of OBRA 1993 Hospital-Specific DSH Limits

Federal financial participation is available only for DSH funding amounts claimed by the State that do not exceed the OBRA 1993 hospital-specific limits established by 42 U.S.C. §1396r-4(g).

1. With respect to each eligible hospital, the determination of the OBRA 1993 limit shall be as follows:

   a. The OBRA 1993 limit shall be based upon each hospital's uncompensated care costs that are determined in accordance with Section E above (for cost-based hospitals) and Appendix 2, Section J (for non-cost based governmental hospitals and non-governmental hospitals) for the applicable payment adjustment year. Except as provided in paragraph b, the hospital's OBRA 1993 limit shall be 100% of its uncompensated care costs.

   b. For those eligible hospitals that are high DSH facilities the OBRA 1993 limits shall be 175% of the hospital's uncompensated care costs determined for the payment adjustment year. For the 2005-06 and 2006-07 payment adjustment years, a high DSH facility's expenditures for the provision of inpatient and outpatient hospital services to uninsured patients for which demonstration funding is claimed by the State will not be excluded from uncompensated care costs for purposes of determining the hospital's OBRA 1993 limit.

   c. Effective October 1, 2021, when determining the OBRA 1993 limit for cost-based hospitals in Section E above as well as for non-cost-based governmental hospitals and non-governmental hospitals based on Appendix 2, Section J, the OBRA 1993 limit will follow the definition of the hospital-specific limit and any applicable exceptions, pursuant to Section 1923(g) of the Social Security Act as amended by the Consolidated Appropriations Act, 2021.

2. With respect to each hospital that is a non cost-based DSH facility, for each payment adjustment year the sum of the payments made to the hospital under subsection D. 1 shall not exceed the OBRA 1993 limit determined for the hospital under subsection F. 1, above.

3. With respect to each hospital that is a cost-based DSH facility, for each payment adjustment year the sum of the direct DSH payments made to the hospital under paragraph D.2.a, plus the amount of the hospital's uncompensated care costs for which the State made cost-based DSH claims from the federal DSH allotment, shall not exceed the OBRA 1993 limit determined for the hospital under subsection F. 1, above.

G. Yearly Reporting and Auditing of DSH Program

In order to qualify for continued federal funding, and satisfy the requirements of Sections 1923(a) (2) (D) and 1923(j) (1) and (2) of the Social Security Act (hereafter "the Act"), the Department will submit an annual, independent certified audit, as required by 42 CFR 455.304(a) and (b), supplemented by a report as detailed in 42 CFR 447.299(c).

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

PRIVATE DISPROPORTIONATE SHARE HOSPITAL REPLACEMENT SUPPLEMENTAL PAYMENTS

Federal financial participation (FFP) for Disproportionate Share Hospital (DSH) Replacement supplemental payments to eligible private hospitals was initially authorized pursuant to California's Section 1115 demonstration project entitled "Medi-Cal Hospital/ Uninsured Care" (No. 11-W-00193/9), effective September 1, 2005 through October 31, 2010, and subsequently authorized pursuant to the successor project entitled "California Bridge to Reform Demonstration" (No. 11-W-00193/9), effective November 1, 2010 through December 31, 2015. This amendment will continue the prior demonstration-based authority under the State Plan to allow for receipt of FFP for DSH Replacement supplemental payments made to eligible private hospitals, effective January 1, 2016.

DSH Replacement payments are fee-for-service inpatient hospital supplemental payments, and are subject to the private hospital upper payment limit as defined in 42 CFR 447.272. As such, DSH Replacement supplemental payments shall not be considered payments made under Section 1923 and shall not be charged against California's federal DSH allotment for an applicable federal fiscal year as described in Section 1923(f).

DSH Replacement Supplemental payments are available for private hospitals identified on the State's disproportionate share list issued by the Department for the project year, and shall be calculated pursuant to the DSH provisions of the State Plan in effect as of the 2004-05 payment adjustment year, set forth in Appendix 2 to this Attachment 4.19-A (entitled the "prior DSH methodology"). The calculation will take into account applicable changes to the OBRA 1993 limit, effective October 1, 2021, pursuant to Section 1923(g) of the Social Security Act, as amended by the Consolidated Appropriations Act, 2021.

A. DSH REPLACEMENT SUPPLEMENTAL PAYMENT CALCULATION AND DISTRIBUTION

1. Interim payments shall be made for the first five months of each project year in the following manner:

    a. Interim payments shall be made to private hospitals identified on the tentative DSH list for the project year provided that the private hospital was also on the final DSH list for the prior project year. The amount of the monthly interim payments shall be equal to one-twelfth of the total payments, based on the private hospital's prior project year payments. "Tentative DSH list" means a draft list of the current project year's DSH-eligible hospitals sent to stakeholders and hospitals for review and confirmation of the hospital's MIUR