DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

February 25, 2020

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: State Plan Amendment (SPA) 19-0019

Dear Ms. Cooper:

We have reviewed the proposed amendment to Attachment 4.19-B of your Medicaid State plan submitted under transmittal number 19-0019. This amendment provides for supplemental payments for private hospital outpatient services for the service period of July 1, 2019 to December 31, 2021. The supplemental payments are in addition to base rate payments and other supplemental payments, paid to private hospitals in California for the furnishing of Medicaid fee-for-service outpatient hospital services. The non-federal share of the supplemental payments are funded by a hospital quality assurance fee, which is a health care-related tax, assessed by the state on hospital services furnished by private hospitals in California.

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 F. We concluded that the proposed amendment is consistent with sections 1902(a), and 1903(a) of the Social Security Act, along with the regulations at 42 CFR 447 Subpart F.

During our state plan amendment review, we ensured:

- These supplemental payments are consistent with Section 1902(a)(30)(A). They are economical and efficient in that these payments, when added to the base rate payments and other supplemental payments received by private hospitals in California, are within the upper payment limits as specified by 42 CFR 447.321. The state provided a demonstration that the aggregate supplemental payment pool amount proposed does not exceed the room available under the upper payment limit for each subject state fiscal period. Because these supplemental payments would represent an increase in reimbursement to the hospitals, it is further reasonable to conclude that there would be no concern that these payments would adversely impact Medicaid access to care or quality of care.

- The state is providing financial participation of these payments in accordance with sections 1902(a)(2) and 1903(a). The non-federal share of these supplemental payments are funded by the state with a permissible health care-related tax, consistent with Section 1903(w)(3). On February 14, 2020, we approved the state's request for a waiver of the tax from broad-based and uniformity criteria, in accordance with 42 CFR 433.68 and 433.72.

- The state met the public process requirements at Section 1902(a)(13).

- The state plan methodology, as written in the state plan amendment, comprehensively specifies the methods and standards used by the state to set the supplemental payments to each qualifying hospital, as required by 42 CFR 447.302.

- The state's submission and CMS' review and processing of the amendment meet all administrative requirements under 42 CFR 430.10-430.20.

Additionally, CMS was involved in litigation, *Asante v. Azar*, 19-2512 (D.D.C. 2019), where certain out-of-state hospitals argued that the state's decision to exclude out-of-state hospitals from these supplemental payments violates the Medicaid statute and various constitutional provisions. Therefore, as part of the review of this state plan amendment, we gave additional consideration to the state's exclusion of out-of-state hospitals and asked the state to further explain its policy goal with this program and its compliance with the Medicaid statue as well as the Constitution's Commerce Clause and Equal Protection Clause.

After careful analysis, we conclude that the exclusion of out-of-state hospitals does not violate the Medicaid statue or the Constitution's Commerce Clause and Equal Protection Clause for the following reasons:

- The base payment rates for out-of-state hospital services, independent of this quality assurance fee-funded supplemental payment, comply with the Medicaid statute, including Section 1902(a)(30)(A). While this state plan amendment does not concern base payment rates, we note that there is no indication or argument raised that the current Medi-Cal payment rates for out-of-state services are insufficient to ensure access of out-of-state Medicaid services to California Medi-Cal beneficiaries. Indeed, Medi-Cal hospital base payment rate methodologies for out-of-state hospitals are fairly consistent with the base payment rate methodologies for in-state California hospitals. For outpatient hospital services, out-of-state hospitals and in-state hospitals are paid under the same fee schedule rate methodology. For inpatient hospital services, out-of-state hospitals and most in-state hospitals are reimbursed under the same general All Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement system. California further extended various aspects of the APR-DRG reimbursement methodology for in-state hospitals to out-of-state border hospitals, which are those located within fifty-five miles from the California border. An example is that, within the APR-DRG rate computation, both in-state hospitals and out-of-state border hospitals receive an adjustment using a hospital-specific wage index, whereas non-border out-of-state hospitals do not get a hospital-specific wage index adjustment. This was to recognize the relatively higher likelihood of these border hospitals treating Medi-Cal beneficiaries due to their proximity to California. Finally, the California state plan further provides that, if Medi-

Cal is required to provide acute inpatient services that are not available in-state to comply with 42 CFR 431.52(b)(3), and the out-of-state hospital refuses to accept the APR-DRG rate, the state may negotiate payments in excess of the APR-DRG rate to provide access to the care.

- Section 1902(a)(16) and the implementing regulation at 42 CFR 431.52, which set forth requirements for furnishing Medicaid services to state residents who are absent from the state, do not require that the payment amounts or methodologies need to be identical between in-state and out-of-state hospitals; those provisions only require that Medicaid, at least in certain circumstances, cover out-of-state medical services for beneficiaries to the same extent as it covers in-state services.

- In regards to how a state may target supplemental payments to particular hospitals, CMS relies on the state to establish the policy goal of each supplemental payment program. In the case of the hospital quality assurance fee supplemental payment program under review, the California legislature has specifically targeted private hospitals licensed as general acute care hospitals under California law. According to the state, "principally, these purposes are to improve access to health care for some of California's most vulnerable residents, improve reimbursement and secure additional federal funds for those hospitals essential to maintaining the Medi-Cal safety net, and to provide funding for healthcare coverage for low income children in California." The state further explains there is "a legislative intent to target…those private hospitals in California that are most likely to service a significant volume of Medi-Cal beneficiaries and thus are integral to maintaining Medi-Cal access." We find California's policy goal here to be reasonable and legitimate. There is no specific Medicaid requirement that would prevent a state from targeting payments to providers as part of its policy goals and objectives, as long as the payments are otherwise in compliance with all Medicaid rules—which, based on our review of this state plan amendment, they are.

- We do not believe the state is in violation of the Commerce Clause by excluding out-of-state hospitals from the supplemental payment. Section 1902 provides clear congressional intent to give states flexibility to set payments rates as they see fit, as long as the rates do not violate Section 1902(a)(30)(A). Indeed, Congress provided that CMS must approve a state plan amendment that is consistent with the requirements in Section 1902(a), which we have determined is the case here. Additionally, as explained by the state in its response to our review questions, the state is exempt from the dormant Commerce Clause because, in setting its Medicaid reimbursement rates and methodologies, it is acting as a market participant rather than a regulator, much like a private insurer participating in the market. In other words, California sets Medicaid rates that it is willing to pay, much like that of a private insurer, and providers can choose to participate or not.

- We also do not believe the state is in violation of the Equal Protection Clause with the exclusion of out-of-state hospitals. As explained by the state in its response to our review questions, out-of-state private hospitals are not "similarly situated" to in-state private hospitals because they do not serve a large portion of California's uninsured and Medi-Cal populations, so their exclusion from this program would not violate the legal doctrine of equal protection. As explained by California, the supplemental payment reflects a legislative attempt to target a specific class of hospitals. It therefore taxes certain California hospitals,

and redistributes the money to those hospitals most likely to serve a significant volume of Medi-Cal beneficiaries.

Out-of-state private hospitals are also not "similarly situated" to in-state private hospitals receiving the supplemental payment because the out-of-state hospitals do not pay the hospital quality assurance fee. Indeed, if they were subject to the quality assurance fee and eligible to receive supplemental payments, they would pay more in fees than they would receive in supplemental payments. They are also not "similarly situated" to those in-state hospitals that are exempt from the fee but are qualified to receive the supplemental payment—namely, small and rural hospitals as defined in Section 124840 of the California Health and Safety Code—because the out-of-state hospitals are not likely to meet that definition even if they were in fact located in California.

But even if the out-of-state hospitals were "similarly situated" to the in-state hospitals, the exclusion of out-of-state hospitals is rationally related to the legitimate state interest of maintaining sufficient access to care and improving reimbursement to those in-state private hospitals that serve the critical role of caring for a disproportionate share of the Medi-Cal population.

In summary, we have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2019. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Blake Holt at (415) 744-3754 or blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Acting Director
Division of Reimbursement Review

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: 19 — 00 19

2. STATE: California

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

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 2019 $ 145,854,676.15
b. FFY 2020 $ 580,097,479.16

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement ~~24~~ 35 to Attachment 4.19-B pages 1-5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ~~Supplement 24 to Attachment 4.19-B pages 1-5~~ N/A: New pages

10. SUBJECT OF AMENDMENT: Supplemental Payments for Hospital Outpatient 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

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: September 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 02/25/2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Todd McMillion

22. TITLE: Acting Director

23. REMARKS

For Box 7, the federal budget impact for FFY 2021 will be $567,582,481.26. The federal budget impact for FFY 2022 will be $139,982,129.15.
For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.
Pen and Ink Change to Boxes 8 and 9 with state concurrence via email dated 12/5/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

SUPPLEMENTAL PAYMENTS FOR HOSPITAL OUTPATIENT SERVICES

This supplemental payment program provides supplemental payments to private hospitals that meet specified requirements and provide outpatient 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.

This supplemental payment program will be in effect from July 1, 2019 through December 31, 2021.

A. Amendment Scope and Authority

This amendment, Supplement 35 to Attachment 4.19-B, describes the payment methodology for providing supplemental payments to eligible hospitals between July 1, 2019 through December 31, 2021. If necessary due to a later State Plan Amendment approval date, payment distributions for subject fiscal quarters that predate federal approval will be made on a condensed timeline.

B. Eligible Hospitals

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

    a. Is licensed pursuant to Health and Safety Code section 1250, subdivision (a).

    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 most recently filed Office of Statewide Health Planning and Development Annual Financial Disclosure Report as of July 1, 2019.

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 as those terms are defined as of July 1, 2019 in paragraphs (26) to (28) of Welfare and Institutions Code section 14105.98, subdivision (a).

e. Is not a non-designated public hospital or a designated public hospital, as those terms are defined as July 1, 2019 in Welfare and Institutions Code section 14169.51, subdivisions (j) and (aj).

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

a. The hospital becomes a Private to Public Converted Hospital pursuant to Paragraph 3 of Section C.

b. The hospital is a new hospital as defined in Paragraph 4 of Section C.

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

d. Any period during which the hospital is deemed closed pursuant to Welfare and Institutions Code section 14169.61, subdivision (c) as in effect on July 1, 2019.

e. The hospital does not have any Medi-Cal fee-for-service outpatient hospital utilization for the subject fiscal quarter.

C. Definitions

For purposes of this supplement, the following definitions will apply:

1. "Hospital outpatient services" means all services covered under Medi-Cal furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services do not include professional services or services for which a managed health care plan is financially responsible, or services rendered by a hospital-based federally qualified health center for which reimbursement is received pursuant to Welfare and Institutions Code section 14132.100.

2. "Outpatient base amount" means the total amount of payments for hospital outpatient services rendered in the 2016 calendar year, as reflected in the state paid claims files prepared by the department as of April 5, 2019.

3. “Private to Public Converted hospital” means a private hospital that becomes a designated public hospital or a non-designated public hospital on or after July 1, 2019.

4. “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.

5. "Program period" means the period from July 1, 2019 through December 31, 2021, inclusive.

6. “Days data source” means either: (1) if a hospital’s Annual Financial Disclosure Report for its fiscal year ending in the 2016 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 May 6, 2019 pursuant to Welfare and Institutions Code section 14169.59, for its fiscal year ending in the 2016 calendar year; or (2) if a hospital’s Annual Financial Disclosure Report for its fiscal year ending in the 2016 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.

7. “Subject fiscal year” means a state fiscal year beginning on or after the first day of a program period and ending on or before the last day of a program period. Subject fiscal year 2019-20 begins on July 1, 2019 and ends on June 30, 2020, subject fiscal year 2020-21 begins on July 1, 2020 and ends on June 30, 2021, and subject fiscal year 2021-22 begins on July 1, 2021 and ends on December 31, 2021.

8. “Subject fiscal quarter” means the quarter to which the supplemental payment is applied. Note that there are only two subject fiscal quarters for subject fiscal year 2021-22.

D. Supplemental Payment Methodology for Private Hospitals

1. Private hospitals will be paid supplemental amounts for the provision of hospital outpatient services. 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. The supplemental amounts will result in payments equal to the amount remaining under the federal upper payment limit for private hospitals for each subject fiscal year.

2. The outpatient base amount shall be those payments for outpatient hospital services rendered in the 2016 calendar year, as reflected in the state paid claims files prepared by the department on April 5, 2019.

3. The outpatient supplemental rate shall be 266 percent of the outpatient base amount for the subject fiscal quarters in the subject fiscal year 2019-20, 261 percent of the outpatient base amount for the subject fiscal quarters in the subject fiscal year 2020-21 and 257 percent of the outpatient base amount for the first two subject fiscal quarters in the subject fiscal year 2021-22. Each amount for subject fiscal years 2019-20 and 2020-21 will be divided by four to arrive at the quarterly amount for the four quarters in both subject fiscal year 2019-20 and subject fiscal year 2020-21 respectively, and the amount for subject fiscal year 2021-22 will be divided by two to arrive at the quarterly amount for the two quarters in the subject fiscal year 2021-22. The above percentages will result in payments to hospitals that equal the applicable federal upper payment limit.

4. In the event that the sum of payments to all hospitals in any subject fiscal quarter causes the aggregate of all supplemental payments to all hospitals pursuant to this Section for all subject fiscal quarters to exceed two billion, four hundred thirty-two million, four hundred sixteen thousand, two hundred forty-two dollars and fifty-seven cents ($2,432,416,242.57), the payments to all hospitals in that subject fiscal quarter shall be reduced pro rata so that the aggregate of all supplemental payments to all hospitals does not exceed two billion, four hundred thirty-two million, four hundred sixteen thousand, two hundred forty-two dollars and fifty-seven cents ($2,432,416,242.57).

5. 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 3 due to the application of a federal upper payment limit, which is subject to annual submission and review, or for any other reason, the following will apply:

    a. The total amount payable to private hospitals under Paragraph 3 for each subject fiscal quarter within the subject fiscal year will be reduced to the amount for which federal financial participation is available pursuant to subparagraph b.

    b. The amount payable under Paragraph 3 to each private hospital for each subject fiscal quarter within the subject fiscal year will be equal to the amount computed under Paragraph 3 multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under Paragraph 3.

    c. In the event that a hospital's payments in any subject fiscal quarter as calculated under Paragraph 3 are reduced by the application of this Paragraph 5, the amount of the reduction will be added to the supplemental

payments for the next subject fiscal quarter within the program period, which the hospital would otherwise be entitled to receive under Paragraph 3, provided further that no such carryover payments will be carried over beyond the period ending December 31, 2021, and such carryover payments will not result in total payments exceeding the applicable federal upper payment limit for the fiscal year.

6. The supplemental payment amounts as set forth in this Supplement are inclusive of federal financial participation.

7. Payments shall be made to a Private to Public Converted hospital that converts during a subject fiscal quarter by multiplying the hospital's outpatient 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 Private to Public Converted hospital in any subsequent subject fiscal quarter.

8. 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 outpatient 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.

9. The Quality Assurance Fee funded supplemental payments will not be treated as offsets in computing the aggregate uncompensated cost list for the specific purpose of making the trauma supplemental payments.