DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 15, 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

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 17-005. This SPA was submitted to my office on March 30, 2017 to provide for supplemental payments, funded by a Quality Assurance Fee (QAF), for private hospital outpatient services for the service period of January 1, 2017 to June 30, 2019.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 24 to Attachment 4.19-B, pages 1-5

If you have any questions, please contact Cheryl Young by phone at (415) 744-3598 or by email at Cheryl.Young@cms.hhs.gov.

Sincerely,

Original signed for Henrietta Sam-Louie

Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: John Mendoza, California Department of Health Care Services (DHCS)
Brie-Anne Sebastian, DHCS
Belinda Rowan, DHCS
Kenneth Lopez, DHCS
Nathaniel Emery, DHCS

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: **17-005**

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**~~ 42 CFR 447, Subpart F

7. FEDERAL BUDGET IMPACT:

a. FFY 2017	$386,321,964.06	~~$515,533,129.19~~
b. FFY 2018	$665,139,149.39	~~$734,125,041.01~~
c. FFY 2019	$500,588,914.97	~~$572,995,739.33~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

~~**Supplement 23 to Attachment 4.19-B**~~
~~**Pages 1-5**~~
Supplement 24 to Attachment 4.19-B, pages 1-5

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

None

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:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Original signed by Mari Cantwell

13. TYPED NAME:
Mari Cantwell

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
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:
March 30, 2017

18. DATE APPROVED:
December 15, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
Original signed for Henrietta Sam-Louie

21. TYPED NAME:
Henrietta Sam-Louie

22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations

23. REMARKS:

Boxes 6, 8, 9 and 15: Pen and ink revisions made by CMS based on revisions submitted by the state on 12/11/17.

Box 7: Pen and ink revisions made by CMS based on revisions submitted by the state on 12/14/17.

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 for a hospital which meets specified requirements and provides 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 January 1, 2017 through June 30, 2019.

A. Amendment Scope and Authority

This amendment, Supplement 23 to Attachment 4.19-B, 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 ending prior to the approval date of the SPA.

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 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 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 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 outpatient hospital utilization for the service period.

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 Section 14132.100.

2. "Outpatient base amount" means the total amount of payments for outpatient hospital services rendered in the 2013 calendar year, as reflected in the state paid claims files prepared by the department as of December 27, 2016.

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 January 1, 2017.

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. “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 outpatient base amount 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 outpatient base amount will be derived from an average of proxy hospitals' outpatient base amount, and adjusted for bed size difference and for any applicable period of closure or non-operation.

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

6. “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.

7. “Subject fiscal year” means state fiscal years 2016-17, 2017-18 and 2018-19.

8. “Service period” means the quarter to which the supplemental payment is applied.

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 2013 calendar year, as reflected in the state paid claims files prepared by the department on December 27, 2016.

3. The outpatient supplemental rate shall be 103 percent of the outpatient base amount for the last two subject fiscal quarters in the subject fiscal year 2016-17, 316 percent of the outpatient base amount for the subject fiscal quarters in the subject fiscal year 2017-18 and 318 percent of the outpatient base amount for the subject fiscal quarters in the subject fiscal year 2018-19. The amount for subject fiscal year 2016-17 will be divided by two to arrive at the quarterly amount for the two quarters in subject fiscal year 2016-17, and each amount for subject fiscal years 2017-18 and 2018-19 will be divided by four to arrive at the quarterly amount for the four quarters in both subject fiscal year 2017-18 and subject fiscal year 2018-19 respectively. 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, seven hundred thirty-seven million, eight hundred six thousand, three hundred eighty dollars and fifty-eight cents ($2,737,806,380.58), the payments to all hospitals in that fiscal quarter shall be reduced pro rata so that the aggregate of all supplemental payments to all hospitals does not exceed two billion, seven hundred thirty-seven million, eight hundred six thousand, three hundred eighty dollars and fifty-eight cents ($2,737,806,380.58).

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 service period within the 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 service period within the 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 service period 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 service period 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 June 30, 2019, 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 converted hospital (Private to Public) 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 converted hospital (Private to Public) 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.