ENCLOSURE **FOR STAKEHOLDERS ONLY

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

11-024 *

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	Insert Page(s)
None	Appendix 5 to Attachment 4.19-A, pages 1-6

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services (CMCS)

JUN 22 2012

Toby Douglas
Director of Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: California State Plan Amendment TN: 11-024

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-024. This amendment provides for supplemental payments, funded by a quality assurance fee, for inpatient hospital services for the service period of July 1, 2011 to December 31, 2013.

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. We are pleased to inform you that Medicaid State plan amendment 11-024 is approved effective July 1, 2011. 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,

Cindy Mann
Director, CMCS

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: 11-024

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, 2011

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 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 11 279,618,084 ~~$266,098,087~~
b. FFY 12 1,145,994,474 ~~$1,107,418,187~~ ~~$1,114,935,300~~
c. FFY 13 1,270,319,038 ~~$1,277,441,875~~ ~~$1,280,470,273~~
d. FFY 14 348,898,377 ~~$358,170,336~~ ~~$360,656,100~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Appendix 5 to Attachment 4-19-A
~~Pages 1-5~~ pages 1-6

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Supplemental Reimbursement 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:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED:
SEP 20 2011

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Pen-and-ink changes made to Boxes 7 and 8 by the Regional Office, with email concurrence by the State dated 6/18/2012.

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 payment program will be in effect from July 1, 2011, through and including December 31, 2013.

A. Amendment Scope and Authority

This amendment, Appendix 5 to Attachment 4.19-A, describes the payment methodology to provide supplemental payments to eligible hospitals between July 1, 2011, and December 31, 2013. 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 2009.

    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 were defined **on July 1, 2011,** 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 converted hospital pursuant to paragraph 1 of Section C.**

   b. **The hospital becomes a new hospital.**

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

C. Definitions

For purposes of this attachment, the following definitions apply:

1. "Converted hospital" means a private hospital that becomes a designated public hospital or a non-designated public hospital on or after July 1, 2011. **(Note: This definition is different from the definition of "converted hospital" as referenced in subparagraph d of paragraph 1 of Section B.)**

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 liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

3. "Acute psychiatric days" means the total number of Short-Doyle administrative days, Short-Doyle acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Tentative Medi-Cal Utilization Statistics for the 2011-12 state fiscal year as calculated by the department on July 21, 2011.

4. "General acute care days" means the total number of Medi-Cal general acute care days paid by the department to a hospital in the 2009 calendar year, as reflected in the state paid claims files on July 15, 2011.

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 during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 15, 2011.

6. "Program period" means the time period from July 1, 2011, through December 31, 2013, inclusive.

7. "Days data source" means the hospital's Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of May 5, 2011, for the fiscal year ending during 2009.

8. "Subject fiscal year" means a state fiscal year that ends after July 1, 2011, and begins before January 1, 2014.

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 twenty four (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 services for which a managed health care plan is financially responsible.

10. "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 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 Hospital Quality Assurance Revenue Fund as established pursuant to Section 14169.11 of the Welfare and Institutions Code as of July 1, 2011***, in the total amount of ***$6,089,659,946***, consisting of the following subpools:

   General acute subpool: ***$4,822,575,800***
   Psychiatric subpool: ***$268,560,275***
   High acuity subpool: ***$882,616,500***
   Subacute subpool: ***$115,907,371.***

   Except as set forth in subparagraph f of paragraph 2 and in paragraph 7, 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 2011-12 subject fiscal year, nine hundred seventy four dollars and ten cents ($974.10) multiplied by the hospital's general acute care days.***

- ***For the 2012-13 subject fiscal year, one thousand eighty nine dollars and ninety-two cents ($1,089.92) multiplied by the hospital's general acute care days.***

- ***For the 2013-14 subject fiscal year, one thousand two hundred sixty-four dollars and six cents ($1,264.06) multiplied by the hospital's general acute care days divided by two (2).***

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 2011-12 subject fiscal year, six hundred ninety-five dollars ($695.00) multiplied by the hospital's covered acute psychiatric days.***

- ***For the 2012-13 subject fiscal year, seven hundred ninety dollars ($790.00) multiplied by the hospital's acute psychiatric days.***

- ***For the 2013-14 subject fiscal year, nine hundred fifty-five dollars ($955.00) multiplied by the hospital's covered acute psychiatric days divided by two (2).***

c. From the high acuity subpool, in addition to the amounts specified in subparagraphs (a) and (b), if the hospital's Medicaid inpatient utilization rate is less than 41.6 percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days:

- ***For the 2011-12 and 2012-13 subject fiscal years, one thousand three hundred fifty dollars ($1,350.00) multiplied by the number of the hospital's high acuity days.***

- ***For the 2013-14 subject fiscal year, one thousand three hundred fifty dollars ($1,350.00) multiplied by the number of the hospital's high acuity days divided by two (2).***

d. From the high acuity 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 July 1, 2011:

- ***For the 2011-12 and 2012-13 subject fiscal years, one thousand three hundred fifty dollars ($1,350.00) multiplied by the number of the hospital's high acuity days.***

- ***For the 2013-14 subject fiscal year, six hundred seventy five dollars ($1,350.00) multiplied by the number of the hospital's high acuity days divided by two (2).***

e. From the subacute subpool, if a private hospital that provided Medi-Cal subacute services during the 2009 calendar year and has a Medicaid inpatient utilization rate that is greater than 5.0 percent and less than 41.6 percent

- ***For the 2011-12 and 2012-13 subject fiscal years, an amount equal to forty percent (40%) of the Medi-Cal subacute payments paid by the department to the hospital during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 14, 2011.***

- ***For the 2013-14 subject fiscal year, an amount equal to twenty percent (20%) of the Medi-Cal subacute payments paid by the department to the hospital during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 14, 2011.***

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 by the percentages listed in each subpool 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 service period is not available for all of the supplemental amounts payable to private hospitals under paragraph 2 due to the application of a federal payment limit or for any other reason, the following will apply:

   a. The total amounts payable to private hospitals under paragraph 2 for the service period 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 the service period 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 service period 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 service period 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 December 31, 2013 and such carryover payments will not result in***

total payments exceeding the applicable federal upper payment limit for the service period.

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

6. ***Beginning with the quarter subsequent to the quarter in which a hospital becomes ineligible pursuant to paragraph 2 of Section B,*** no further payments will be made pursuant to this Appendix to **that** hospital.

7. No payments will be made pursuant to this Appendix to a new hospital.

8. For as long as the selective provider contracting program is in effect, the amount of any supplemental payment for a new noncontract hospital shall be reduced by the amount by which that hospital's overall payment for services for Medicaid beneficiaries during the program period was increased by reason of its becoming a noncontract hospital.