REQUEST FOR STAKEHOLDER INPUT ON PROPOSED STATE PLAN AMENDMENTS 17-004 AND 17-005 PROPOSING SUPPLEMENTAL PAYMENTS UP TO THE UPPER PAYMENT LIMIT FOR CERTAIN GENERAL ACUTE CARE HOSPITALS

The Department of Health Care Services (DHCS) requests input from beneficiaries, providers and other interested stakeholders concerning the below State Plan Amendments (SPA, no.17-004 and 17-005) language proposing inpatient and outpatient supplemental payments for State Fiscal Years (SFY) 2016-17, 2017-18 and 2018-19 pursuant to Article 5.230 of the Welfare and Institutions Code (commencing with section 14169.50).

SPA 17-004 proposes inpatient supplemental payments for certain general acute care hospitals up to the Inpatient Upper Payment Limit (UPL). SPA 17-005 proposes outpatient supplemental payments for certain general acute care hospitals up to the Outpatient UPL.

SPA 17-004 and 17-005 are in draft form, not final and contain tentative payment amounts and rates which are subject to change.

The proposed SPAs are subject to approval by the federal Centers for Medicare & Medicaid Services (CMS).

DHCS is requesting stakeholder input, questions and concerns on the impact, if any, on continued service access as a result of the proposed action.

To be assured of consideration prior to SPA submission to CMS, comments must be received no later than 5 p.m. on March 18, 2017. DHCS requests that all comments be submitted via email to PublicInput@dhcs.ca.gov and reference SPA 17-004 and 17-005. Please note that comments will continue to be accepted after March 18, 2017, but DHCS will be unable to consider those comments prior to the initial submission of SPAs 17-004 and 17-005 to CMS.
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 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.

The supplemental payment program will be in effect from January 1, 2017, through June 30, 2019.

A. Amendment Scope and Authority

This amendment, Appendix 7 to Attachment 4.19-A, 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 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 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, 2014, 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 Private to Public Converted Hospital pursuant to Paragraph 1 of Section C.

b. The hospital is a new hospital as defined in Paragraph 2 of Section C.

c. The hospital does not meet with 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.

C. Definitions

For purposes of this attachment, the following definitions apply:

1. “Private to Public Converted hospital” means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after January 1, 2017.

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 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 14165.50, subdivision (f), as that section reads as of January 1, 2017, and for such a hospital, the number of Medi-Cal patient days 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 number of Medi-Cal days will be derived from an average of proxy hospitals' Medi-Cal patient days, and adjusted for bed size difference and for any applicable period of closure or non-operation.

3. “Acute psychiatric days” means the total number of Medi-Cal specialty mental health service administrative days, Medi-Cal specialty mental health service acute care days, acute psychiatric administrative days, and acute psychiatric acute days for the 2013 calendar year as calculated by the department on December 17, 2016 and were paid directly by the department and were not the financial responsibility of a mental health plan.

4. “General acute care days” means the total number of Medi-Cal general acute care days, including well baby days, less any acute psychiatric inpatient days, paid by the department to a hospital for services in the 2013 calendar year, as reflected in the state paid claims file on December 28, 2016.

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 to a hospital for services in the 2013 calendar year, as reflected in the state paid claims file prepared by the department on the December 28, 2016.

6. “Program period” means the time period from January 1, 2017, through June 30, 2019, inclusive.

7. “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.

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 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 professional services or services for which a managed health care plan is financially responsible.

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

11. “Subacute supplemental payment” means a fixed proportional supplemental payment for acute inpatient services based on a hospital’s prior provision of Medi-Cal subacute services.

12. “Medicaid Inpatient Utilization Rate” means the final Medicaid utilization statistics computed for the 2015-16 state fiscal year for disproportionate share hospital payment purposes, as reflected in the state paid claims file based on calendar year 2013 data and calculated by the department as of December 17, 2016. The Department may correct any identified material and egregious errors in the data.

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 total amount of six billion dollars ($6,000,000,000), consisting of the following subpools:

   General Acute Subpool: $4,344,731,862.55
   Psychiatric Subpool: $104,718,909.99
   High Acuity Subpool: $854,899,603.72
   High Acuity Trauma Subpool: $259,856,250.00
   Subacute Subpool: $387,549,623.75
   Transplant Subpool: $48,243,750.00
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 last two subject fiscal quarters of 2016-17 subject fiscal year, one thousand, one hundred and thirty one dollars and sixty-six cents ($1,131.66) multiplied by half of the hospital’s annual general acute care days.

- For the 2017-18 and 2018-19 subject fiscal year, one thousand, one hundred and thirty one dollars and sixty-six cents ($1,131.66) multiplied by the hospital’s general acute care days.

**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 last two subject fiscal quarters of 2016-17 subject fiscal year, nine hundred and seventy-five dollars ($975) multiplied by half of the hospital’s annual covered acute psychiatric days.

- For the 2017-18 and 2018-19 subject fiscal year, nine hundred and seventy-five dollars ($975) multiplied by the hospital’s acute psychiatric days.

**c. From the high acuity subpool,** in addition to the amount specified in Subparagraphs a and b, if the hospital’s Medicaid inpatient utilization rate is less than the 41.6 percent for the state fiscal year ending in the 2013 calendar year and greater than 5 percent, and at least 5 percent of the hospital’s general acute care days are high acuity days:

- For 2016-17 subject fiscal year two thousand and five hundred dollars ($2,500) will be multiplied by half of the hospital’s annual high acuity days. For the 2017-18 and 2018-19 subject fiscal years two thousand and five hundred dollars ($2,500) multiplied by the number of the hospital’s high acuity days.
d. From the high acuity trauma 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 January 1, 2017:

- For 2016-17 subject fiscal year two thousand and five hundred dollars ($2,500) will be multiplied by half of the hospital’s annual high acuity days. For the 2017-18 and 2018-19 subject fiscal years two thousand and five hundred dollars ($2,500) multiplied by the number of the hospital’s high acuity days.

e. From the subacute subpool, if a private hospital that provided Medi-Cal subacute services during the 2013 calendar year and has a Medicaid inpatient utilization rate that is greater than 5 percent and less than 41.6 percent:

- The subacute supplemental rate shall be 30 percent (half of 60 percent) for the two remaining subject fiscal quarters in the 2016-17 subject fiscal year, 60 percent for the subject fiscal quarters in the 2017-18 subject fiscal year, 60 percent for the subject fiscal quarters in the 2018-19 subject fiscal year of the Medi-Cal subacute payments paid by the department to the hospital for services during the 2013 calendar year, as reflected in the state paid claims file prepared by the department on December 28, 2016.

f. From the transplant subpool, in addition to Subparagraphs (a.), (b.), (c.), (d.), and (e.), a private hospital that has Medi-Cal days for Medicare Severity-Diagnosis Related Groups 1, 2, 5 to 10, inclusive, 14, 15, and 652, according to the Patient Discharge file from the Office of Statewide Health Planning and Development for the 2013 calendar year assessed on December 27:

- For 2016-17 two thousand and five hundred dollars ($2,500) will be multiplied by half of the hospital’s annual Medi-Cal days for Medicare Severity-Diagnosis Related Groups identified above. For 2017-18 and 2018-19 subject fiscal years, two thousand and five hundred dollars ($2,500) multiplied by the number of Medi-Cal days.

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, which is subject to annual submission and review, 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 June 30, 2019, 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. 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 inpatient 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.

7. Payments shall be made to a converted hospital (Private to Public) which converts during a subject fiscal quarter by multiplying the hospital’s inpatient 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.
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 and including June 30, 2019.

A. Amendment Scope and Authority

This amendment, Supplement 22 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.

C. 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, 2014, 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.

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 14165.50, subdivision (f), 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.


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 108 percent of the outpatient base amount for the two remaining subject fiscal quarters in the 2016-17 subject fiscal year, 215 percent of the outpatient base amount for the subject fiscal quarters in the 2017-18 subject fiscal year, and 215 percent of the outpatient base amount for the subject fiscal quarters in the 2018-19 subject fiscal year. 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 dollars ($2,000,000,000), the payments to all hospitals in that fiscal quarter shall be reduced by the applicable percentages so that the aggregate of all supplemental payments to all hospitals does not exceed two billion dollars ($2,000,000,000).

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

   a. The total amount payable to private hospitals under Paragraph 2 for the service period will be reduced to the amount for which federal financial participation is available pursuant to subparagraph b.
b. The amount payable under Paragraph 2 to each private hospital for the service period will be equal to the amount computed under Paragraph 2 multiplied by the ratio of the total amount for which federal financial participation is available to the total amount 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 June 30, 2019, and such carryover payments will not result in total payments exceeding the applicable federal upper payment limit for the service period.

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 QAF-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.