STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

SUPPLEMENTAL REIMBURSEMENT FOR HOSPITAL OUTPATIENT SERVICES

This program provides supplemental reimbursement for a hospital which meets specified requirements and provides outpatient services to Medi-Cal beneficiaries.

Supplemental payments to hospitals shall be up to the aggregate upper payment limit for the category of hospitals receiving the payments.

Supplemental payments shall be made periodically on a lump-sum basis throughout the duration of the program, and shall not be paid as individual increases to current reimbursement rates for specific services.

This supplemental payment program shall be in effect from January 1, 2011 through and including September 30, 2011.

A. Amendment Scope and Authority

1. This amendment, Supplement 13 to Attachment 4.19-B, provides the authority to implement a payment methodology to provide supplemental payments to eligible hospitals between January 1, 2011, and September 30, 2011.

B. Eligible Hospitals

1. Hospitals eligible for supplemental payments under this amendment are private hospitals, as defined below.

   (a) "Private hospital" means a hospital that meets all of the following conditions:

      (1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code as of June 29, 2009.

      (2) 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 2007.

      (3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of W&I Code Section 14105.98 as of April 13, 2011.

C. Definitions

1. For purposes of this supplement, the following definitions shall apply:

(a) "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 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 of W&I Code as of April 13, 2011.

(b) "Outpatient base amount" means the total amount of payments for hospital outpatient services made to a hospital in the 2007 calendar year, as reflected in state paid claims files on January 26, 2008, and does not include outpatient state supplemental payments (known as DSH payments) or trauma payments.

(c) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after January 1, 2011, a nondesignated public hospital that becomes a private hospital or a designated public hospital on or after January 1, 2011, or a designated public hospital that becomes a private hospital or a nondesignated public hospital on or after January 1, 2011.

(d) "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.

(e) "Program period" means the period from January 1, 2011 through September 30, 2011, inclusive.

(f) "Days data source" means the following:

(1) For a hospital that did not submit an Annual Financial Disclosure Report to the Office of Statewide Health Planning and Development for a fiscal year ending during 2007, but submitted that report for a fiscal period ending in

2008 that includes at least 10 months of 2007, the Annual Financial Disclosure Report submitted by the hospital to the Office of Statewide Health Planning and Development for the fiscal period in 2008 that includes at least 10 months of 2007.

(2) For a hospital owned by Kaiser Foundation Hospitals that submitted corrections to reported patient days to the Office of Statewide Health Planning and Development for its fiscal year ending in 2007 before July 31, 2009, the corrected data.

(3) For all other hospitals, the hospital's Annual Financial Disclosure Report in the Office of Statewide Health Planning and Development files as of October 31, 2008, for its fiscal year ending during 2007.

D. Supplemental Payment Methodology

1. Private hospitals shall be paid supplemental amounts for the provision of hospital outpatient services as set forth in this section. 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.

2. Except as set forth in subsections (6) and (7), each private hospital shall be paid an amount for the program period equal to a percentage of the hospital's outpatient base amount. The percentage shall be the same for each hospital and shall result in payments to hospitals that equal the applicable payment limit, less any amounts paid pursuant to Supplement 12 to Attachment 4.19B and accounted toward the federal upper payment limits for the entire 2010-11 fiscal year. The percentage for the program period shall be derived as follows:

   (a) Calculate the difference between the aggregate outpatient hospital payments to private hospitals in the fiscal year of payment (other than under this section) and the aggregate upper payment limit for outpatient hospital services for private hospitals in that year;

   (b) Calculate the percentage that the difference is to the sum of all hospitals' outpatient base amount. The percentage shall be the same for every hospital for a fiscal year.

   (c) Multiply the percentage obtained in subdivision (b) by .5.

3. In the event that the sum of payments to all hospitals causes the aggregate of all supplemental payments to all hospitals pursuant to this section to exceed $509,080,303, the payments to all hospitals shall be reduced pro rata so that the

aggregate of all supplemental payments to all hospitals does not exceed $509,080,303.

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 subsection (2) due to the application of a federal upper limit or for any other reason, both of the following shall apply:

   (a) The total amount payable to private hospitals under subsection (2) for the service period shall be reduced to the amount for which federal financial participation is available.

   (b) The amount payable under subsection (2) to each private hospital for the service period shall be equal to the amount computed under subsection (2) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subsection (2).

5. The supplemental amounts set forth in this section are inclusive of federal financial participation.

6. No payments shall be made under this section to a new hospital.

7. No payments shall be made under this section to a converted hospital.