



State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

March 28, 2014

Ms. Gloria Nagle  
Associate Regional Administrator  
Centers for Medicare and Medicaid Services  
Division of Medicaid and Children's Health  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6707

**STATE PLAN AMENDMENT Nos. 14-002**

Dear Ms. Nagle:

The Department of Health Care Services ( DHCS) is submitting the enclosed State Plan Amendment (SPA) to allow supplemental reimbursement to hospitals for the provision of outpatient services to Medi-Cal beneficiaries. This SPA, Supplement 22 to Attachment 4.19-B for outpatient services, will make changes to California's Medicaid State Plan under Title XIX of the Social Security Act.

The primary purpose of this SPA is to allow DHCS to issue supplemental payments to hospitals up to the aggregate upper payment limit without supplanting specified existing levels of payments. The effective date of the SPAs will be January 1, 2014. If you have any questions or concerns regarding the proposed provisions, please contact Mr. John Mendoza, Division Chief, Safety Net Financing Division at (916) 552-9130.

Sincerely,

Originally signed by Mari Cantwell for Toby Douglas

Toby Douglas  
Director  
Department of Health Care Services

Enclosure

cc: See Next Page

Ms. Gloria Nagle

Page 2

cc: Bruce Lim, Deputy Director  
Audits and Investigations Division  
Department of Health Care Services  
MS 2000  
P.O. Box 997413  
Sacramento, CA 95899-7413

John Mendoza  
Division Chief  
Safety Net Financing Division  
Department of Health Care Services  
MS 4504  
P.O. Box 997419  
Sacramento, CA 95899-7419

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**14-002**

2. STATE  
CA

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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, 2014

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:  
75 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT:  
a. FFY 13/14 \$933,853,661      FFY 15/16 \$1,298,388,741  
b. FFY 14/15 \$1,155,243,223      FFY 16/17 \$349,857,317

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Supplement 22 to Attachment 4.19-B  
Pages 1-6

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  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

10. SUBJECT OF AMENDMENT:  
Supplemental Reimbursement 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:  
Originally signed by Mari Cantwell for Toby Douglas

16. RETURN TO:

13. TYPED NAME:  
**Toby Douglas**

**Department of Health Care Services  
Attn: State Plan Coordinator  
1501 Capitol Avenue, Suite 71.326  
P.O. Box 997417  
Sacramento, CA 95899-7417**

14. TITLE:  
**Director**

15. DATE SUBMITTED: March 28, 2014

**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:

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**STATE: CALIFORNIA

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**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, 2014, through and including December 31, 2016.

**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, 2014, and December 31, 2016. 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 2010.

TN 14-002

Supersedes

TN:   N/A  

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Effective Date:   January 1, 2014

- 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.

### 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 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 hospital outpatient services made to a hospital in the 2010 calendar year, as reflected in the state paid claims files prepared by the department as of March 11, 2014.
3. "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, 2014.
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.

TN 14-002

Supersedes

TN: N/A

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2014

5. "Program period" means the period from January 1, 2014, through December 31, 2016, 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 June 6, 2013 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 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.
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 services made to a hospital in the 2010 calendar year, as reflected in the state paid claims files prepared by the department on April 26, 2013.
3. The percentage will result in payments to hospitals that equal the applicable federal upper payment limit, The outpatient supplemental rate shall be 150 percent of the outpatient base amount for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, 257 percent of the outpatient base amount for the subject fiscal quarters in the 2014–15 subject fiscal year, 290 percent of the outpatient base amount for the subject fiscal quarters in the 2015–16 subject fiscal year, and 160 percent of the outpatient base amount for the first two subject fiscal quarters in the 2016–17 subject fiscal year.
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 \$3,737,342,941, the payments to all hospitals in that fiscal quarter shall be reduced by the applicable percentages so

TN 14-002

Supersedes

TN: N/A

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2014

that the aggregate of all supplemental payments to all hospitals does not exceed \$3,737,342,941.

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 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 December 31, 2016 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 Appendix 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.
9. 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 Supplement to that hospital.
10. 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.

TN 14-002

Supersedes

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Approval Date: \_\_\_\_\_

Effective Date: January 1, 2014

### E. Out of State Hospitals

1. Out of State Hospitals will be paid supplemental amounts for the provision of hospital outpatient services for the program period in which they elect to participate. 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. An out of state hospital will be deemed eligible for this program if it has met the following requirements:
  - a. Notify the California Department of Health Care Services (DHCS or Department) in writing of its intent to participate in the HQAF Program by January 1 for each annual HQAF period (July 1 through June 30) for which the out of state hospital elects to participate or within 30 days of approval of this State Plan Amendment for HQAF periods January 1, 2014-June 30, 2015.
  - b. Is a private general acute care hospital licensed outside the state of California, which has accrued Medi-Cal days by providing medical services to Medi-Cal beneficiaries.
  - c. Enter into a written agreement with DHCS agreeing to comply with the HQAF program requirements as if the Out of State hospital resided in the state of California notwithstanding the requirements outlined in Section B, except for B.1.c.
  - d. Provide DHCS with reliable data necessary to calculate fees and supplemental payments calculated pursuant to this Supplement.
2. Out of State private hospital supplemental payments will be calculated using the methodology as defined in Section D, with the exception of Section D, Paragraph 2. The outpatient base amount shall be those payments for outpatient services made to an out of state private hospital in the 2010 calendar year. Supplemental payments to hospitals will be up to the aggregate private hospital out of state upper payment limit.
3. No payments will be made pursuant to this Supplement to a new hospital as defined in Section C.
4. In the event federal approval is not received or federal financial participation for a service period is not available for the supplemental amounts payable for Out of State Hospitals, any fees received by the Department from the Out of State Hospitals shall be returned to the contributing hospitals.

TN 14-002

Supersedes

TN: N/A

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2014

5. If a hospital becomes ineligible pursuant to Paragraph 2 of Section B, then the hospital must return all the payments it received beginning in the quarter it became ineligible.

TN 14-002

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