

March 30, 2026

THIS LETTER SENT VIA EMAIL

Ms. Courtney Miller, Director
Division of Program Operations
Medicaid and CHIP Operations Group
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 355
Kansas City, MO 64106

STATE PLAN AMENDMENT 26-0005: SUPPLEMENTAL PAYMENTS FOR HOSPITAL
OUTPATIENT SERVICES

Dear Ms. Miller:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 26-0005 for your review and approval. This SPA proposes to make changes to California's Medicaid State Plan under Title XIX of the Social Security Act, as it proposes to update Supplement 43 to Attachment 4.19-B. DHCS seeks an effective date of January 1, 2026, for this SPA.

If approved, SPA 26-0005 will allow supplemental reimbursement to hospitals up to the aggregate upper payment limit (UPL) without supplanting payments to which hospitals would otherwise be entitled for the provision of outpatient services to Medicaid beneficiaries.

In accordance with federal regulations, a public notice for SPA 26-0005 was published on December 30, 2025. In addition, DHCS has determined that a Tribal notice is not necessary for this proposal.

The following SPA documents are enclosed for your review and approval:

- CMS 179 Form
- Supplement 43 to Attachment 4.19-B - NEW
- Public Notice and Addendum



Ms. Miller

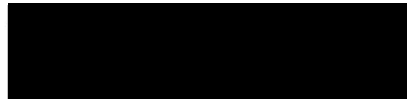
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- Responses to Outpatient Standard Funding Questions
- HQAF X Broad-Based Waiver Letter
- Outpatient Hospital UPL Guidance

If you have any questions or need additional information, please contact Ms. Katie Brooks, Chief, Safety Net Financing Division at (916) 345-7937 or by e-mail at Katie.Brooks@dhcs.ca.gov.

Sincerely,



Tyler Sadwith
State Medicaid Director
Chief Deputy Director, Health Care Programs
California Department of Health Care Services

Enclosures

cc: Saralyn M. Ang-Olson, JD, MPP
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**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 6 — 0 0 0 5

2. STATE

CA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

January 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2025-26 \$ 679,812,128
b. FFY 2026-27 \$ 226,604,043

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 43 to Attachment 4.19-B pages 1-5 New

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
None

9. SUBJECT OF AMENDMENT
Supplemental Payments for Hospital Outpatient Services

10. 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:

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

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Tyler Sadwith

13. TITLE
State Medicaid Director and Chief Deputy Director

14. DATE SUBMITTED
March 30, 2026

15. RETURN TO

Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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 to private hospitals that meet specified requirements and provide 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, 2026, through December 31, 2026.

A. Amendment Scope and Authority

This amendment, Supplement 43 to Attachment 4.19-B, describes the payment methodology for providing supplemental payments to eligible hospitals from January 1, 2026, through December 31, 2026. If necessary due to a later State Plan Amendment approval date, payment distributions for subject fiscal quarters that predate federal approval will be made on a condensed timeline.

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 Health and Safety Code section 1250, subdivision (a).
 - 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 most recently filed Department of Health Care Access and Information (formerly known as Office of Statewide Health Planning and Development) Annual Financial Disclosure Report as of January 1, 2026.

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TN NONE

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- c. Does not satisfy the Medicare criteria to be classified as a long-term care hospital, as defined on January 1, 2026, in the Social Security Act section 1886, subdivisions (d)(1)(B)(iv).
 - d. Is a nonpublic hospital, nonpublic converted hospital, or converted hospital, as defined on January 1, 2026, in Welfare and Institutions Code section 14105.98, subdivision (a), paragraphs (26) to (28).
 - e. Is not a non-designated public hospital or a designated public hospital, as defined on January 1, 2026, in Welfare and Institutions Code section 14169.51, subdivisions (j) and (aj).
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 set forth in Paragraph 1.
 - d. Any period during which the hospital is deemed closed pursuant to Welfare and Institutions Code section 14169.61, subdivision (c) as in effect on January 1, 2026.
 - e. The hospital does not have any Medi-Cal fee-for-service outpatient hospital utilization for the subject fiscal quarter.

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 Welfare and Institutions Code section 14132.100.
2. “Outpatient base amount” means the total amount of payments for hospital outpatient services rendered in the 2023 calendar year, as reflected in the state paid claims files prepared by the department as of October 1, 2025.

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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, 2026.
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.
5. “Program period” means the period from January 1, 2026, through December 31, 2026, inclusive.
6. “Days data source” means either: (1) if a hospital’s Annual Financial Disclosure Report for its fiscal year ending in the 2023 calendar year includes data for a full fiscal year of operation, the hospital’s Annual Financial Disclosure Report retrieved from the Department of Health Care Access and Information by the department on October 2, 2025, pursuant to Welfare and Institutions Code section 14169.59, for its fiscal year ending in the 2023 calendar year; or (2) if a hospital’s Annual Financial Disclosure Report for its fiscal year ending in the 2023 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 2025-26 and 2026-27.
8. “Subject fiscal quarter” means the quarter to which the supplemental payment is applied. Note that there are only two subject fiscal quarters for subject fiscal year 2025-26, and there are two subject fiscal quarters for subject fiscal year 2026-27.
9. “Calendar year” means the year beginning on or after the first day of the third quarter of a state fiscal year and ending on the last day of the second quarter for the following state fiscal year. Calendar year 2026 begins on January 1, 2026, and ends on December 31, 2026.

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 the calendar year.

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2. The outpatient supplemental rate for calendar year 2026 shall be three hundred ninety-three percent of the outpatient base amount. The amount for calendar year 2026 will be divided by four to arrive at the quarterly amount for the four quarters in calendar year 2026. The above percentage will result in payments to hospitals that equal the applicable federal upper payment limit.
3. 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 one billion, five hundred sixty-two million, seven hundred eighty-six thousand, five hundred one dollars (\$1,562,786,501), the payments to all hospitals in that subject fiscal quarter shall be reduced pro rata so that the aggregate of all supplemental payments to all hospitals does not exceed one billion, five hundred sixty-two million, seven hundred eighty-six thousand, five hundred one dollars (\$1,562,786,501).
4. In the event federal financial participation for a calendar year 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, the following will apply:
 - a. The total amount payable to private hospitals under Paragraph 2 for each subject fiscal quarter within the calendar year will be reduced to the amount for which federal financial participation is available pursuant to subparagraph b of this paragraph.
 - b. The amount payable under Paragraph 2 to each private hospital for each subject fiscal quarter within the calendar year 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 subject fiscal quarter 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 fiscal quarter 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 December 31, 2026, and such carryover payments will not result in total payments exceeding the applicable federal upper payment limit for the fiscal year.
5. The supplemental payment amounts as set forth in this Supplement are inclusive of federal financial participation.
6. Payments shall be made to a Private to Public Converted hospital that converts

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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 Private to Public Converted hospital in any subsequent subject fiscal quarter.

7. 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.