

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

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**SUPPLEMENTAL REIMBURSEMENT FOR HOSPITAL INPATIENT SERVICES**

This program provides supplemental reimbursement to private hospitals which meet specified requirements and provide inpatient services to Medi-Cal beneficiaries.

Supplemental payments to hospitals shall be up to the aggregate upper payment limit.

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.

The 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, Appendix 4 to Attachment 4.19-A, 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 include 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 attachment, the following definitions shall apply:

- (a) "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.
- (b) "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.
- (c) "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 Final Medi-Cal Utilization Statistics for the 2008-09 state fiscal year as calculated by the department on September 15, 2008.
- (d) "General acute care days" means the total number of Medi-Cal general acute care days paid by the department to a hospital in the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.
- (e) "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 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.
- (f) "Program period" means the time period from January 1, 2011, through September 30, 2011, inclusive.
- (g) "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

Each hospital's supplemental payment is based on applying various specific rates for different levels of care to the paid days for each level of care.

##### 1. Private Hospitals:

- (a) Private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services 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.
- (b) From a pool of funds in the total amount of \$1,067,081,023, consisting of the following subpools:
  - General acute subpool: \$837,255,905
  - Psychiatric subpool: \$53,021,170
  - High acuity subpool: \$161,070,525
  - Sub-acute subpool: \$15,733,423

except as set forth in subdivisions (e) and (f) and in paragraph (6) of this subdivision, private hospitals will be paid 50 percent of the following supplemental amounts for the provision of hospital inpatient services for the program period:

- (1) From the general acute subpool, nine hundred eleven dollars and forty-eight cents (\$911.48) multiplied by the hospital's general acute care days in calendar year 2008.
- (2) From the psychiatric subpool, four hundred eighty-five dollars (\$485) multiplied by the hospital's acute psychiatric days that were paid directly by the department in state fiscal year 2008-2009 and were not the financial responsibility of a mental health plan.

- (3) From the high acuity subpool, one thousand three hundred fifty dollars (\$1,350) multiplied by the number of the hospital's high acuity days in calendar year 2008 if the hospital's Medicaid inpatient utilization rate is less than 41.1 percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days. This amount shall be in addition to the amounts specified in paragraphs (1) and (2).
  - (4) From the high acuity subpool, one thousand three hundred fifty dollars (\$1,350) multiplied by the number of the hospital's high acuity days in calendar year 2008 if the hospital qualifies to receive the amount set forth in paragraph (3) 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 of June 29, 2009. This amount shall be in addition to the amounts specified in paragraphs (1), (2), and (3).
  - (5) From the sub-acute pool a qualifying private hospital that provides Medi-Cal subacute services during the program period and has a Medicaid inpatient utilization rate that is greater than 5.0 percent and less than 41.1 percent shall be paid for the provision of subacute services a supplemental amount equal to 20 percent of the Medi-Cal subacute payments made to the hospital during the 2008 calendar year.
  - (6) In the event that payment of all of the amounts for the program period from any subpool 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 shall be reduced pro rata so that the total amount of all payments from that subpool does not exceed the subpool amount.
- (c) In the event federal financial participation for a service period is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of a federal limit or for any other reason, both of the following shall apply:
- (1) The total amounts payable to private hospitals under subdivision (b) for the service period shall be reduced to reflect the amounts for which federal financial participation is available.
  - (2) The amounts payable under subdivision (b) to each private hospital for the service period shall be equal to the amounts computed under subdivision (b) multiplied by the ratio of the total amounts for which federal financial participation is available to the total amounts computed under subdivision (b).

- (d) The amounts set forth in this section are inclusive of federal financial participation.
- (e) No payments shall be made under this section to a converted hospital.
- (f) No payments shall be made under this section to a new hospital.

TN 11-006

Supersedes

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