



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. 14-001

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 inpatient services to Medi-Cal beneficiaries. This SPA, Appendix 7 to Attachment 4.19-A for inpatient 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

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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:
14-001

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:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 13/14 \$ 1,241,962,628 FFY 15/16 \$ 1,761,220,676
b. FFY 14/15 \$ 1,540,230,252 FFY 16/17 \$ 488,744,349

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Appendix 7 to Attachment 4.19-A
Pages 1-7

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

10. SUBJECT OF AMENDMENT:
Supplemental Reimbursement for Hospital Inpatient 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

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, 2014, through and including December 31, 2016.

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, 2014, and December 31, 2016. 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 2010.
 - c. Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

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- 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.

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, 2014.
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.
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 2010 calendar year as calculated by the department on February 18, 2014.
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 2010 calendar year, as reflected in the state paid claims file on April 26, 2013.
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 2010

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calendar year, as reflected in the state paid claims file prepared by the department on the April 26, 2013.

6. "Program period" means the time period from January 1, 2014, through December 31, 2016, 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 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.
8. "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.
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 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 days" means a fixed proportional supplemental payment for acute inpatient services based on a hospital's prior provision of Medi-Cal subacute services.

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 \$10,064,315,808, consisting of the following subpools:

General acute subpool: \$7,286,902,973

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Psychiatric subpool: \$557,348,000
High acuity subpool: \$1,317,547,500
High acuity trauma subpool: \$404,025,000
Subacute subpool: \$444,229,835
Transplant subpool: \$54,262,500

Except as set forth in Subparagraph f of Paragraph 2 and in Paragraph 7, 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 2013-14 subject fiscal year, (\$1,289.41) multiplied by the hospital's general acute care days.
 - For the 2014-15 subject fiscal year, (\$1,029.99) multiplied by the hospital's general acute care days.
 - For the 2015-16 subject fiscal year, (\$1,232.00) multiplied by the hospital's general acute care days.
 - For the first two subject fiscal quarters of 2016-17 subject fiscal year, (\$1,490.97) 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 first two subject fiscal quarters of 2013-14 subject fiscal year, (\$965) multiplied by the hospital's covered acute psychiatric days.
 - For the 2014-15 subject fiscal year, (\$970) multiplied by the hospital's acute psychiatric days.
 - For the 2015-16 subject fiscal year, (\$975) multiplied by the hospital's acute psychiatric care days.
 - For the 2016-17 subject fiscal year, (\$975) multiplied by the hospital's acute psychiatric care 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 43% for the state fiscal year ending in the 2010 calendar

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year and greater than 5 percent, and at least 5 percent of the hospital's general acute care days are high acuity days:

- For the 2013-14, 2014-15, 2015-16, and 2016-17 subject fiscal years, (\$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 July 1, 2011:
- For the 2013-14, 2014-15, 2015-16, and 2016-17 subject fiscal years, (\$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 2010 calendar year and has a Medicaid inpatient utilization rate that is greater than 5 percent and less than 43 percent:
- The subacute supplemental rate shall be 50 percent for the two remaining subject fiscal quarters in the 2013–14 subject fiscal year, 55 percent for the subject fiscal quarters in the 2014–15 subject fiscal year, 60 percent for the subject fiscal quarters in the 2015–16 subject fiscal year, and 60 percent for the first two subject fiscal quarters in the 2016–17 subject fiscal year of the Medi-Cal subacute payments paid by the department to the hospital during the 2010 calendar year, as reflected in the state paid claims file prepared by the department on April 26, 2013.
- 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, or 652, according to the Patient Discharge file from the Office of Statewide Health Planning and Development for the 2010 calendar year assessed on June 28, 2011:
- For the 2013-14, 2014-15, 2015-16, and 2016-17 subject fiscal years, (\$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

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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 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 December 31, 2016 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. 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 Appendix to that hospital.
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.

E. Out of State Hospitals

1. Out of State Hospitals will be paid supplemental amounts for the provision of hospital inpatient services for the program period in which they elect to

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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. 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.
 5. The payment amounts set forth in this Appendix are inclusive of federal financial participation.
 6. 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.

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Supersedes

TN: None

Approval Date: _____

Effective Date: January 1, 2014