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

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Center for Medicaid, CHIP and Survey & Certification
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

CALIFORNIA REQUEST FOR WAIVER FOR HOSPITAL FEE - PHASE 6

Dear Ms. Fan:

On November 8, 2016, California voters approved Ballot Proposition no. 52 to permanently extend the current version of the State's Hospital Quality Assurance Fee program. (Cal. Const., art. XVI, § 3.5, added by Initiative, Gen. Elec. (Nov. 8, 2016), commonly known as Prop. 52.) The California Department of Health Care Services (California) submits this letter requesting a waiver of the broad-based and uniformity provisions pursuant to 42 CFR §433.72, and concurrent with submission of proposed Medi-Cal State Plan Amendments 19-0018 and 19-0019. This next iteration of the hospital fee (which we refer to as the Phase 6 fee) applies to the period July 1, 2019 through December 31, 2021. The terms and conditions for the Phase 6 fee are substantially the same as those for which the prior waivers were granted.

California requests approval of a waiver of the broad-based and uniformity provisions of section 1903(w)(3)(B) and (C) of the Social Security Act, with a requested effective date of July 1, 2019. The terms of the Phase 6 fee for which the waiver is sought are as follows:

(i) Public hospitals are excluded from the fee;
(ii) Small and rural hospitals are excluded from the fee;
(iii) Psychiatric and specialty hospitals are excluded from the fee;
(iv) Out of State Hospitals are excluded from the fee and payments;
(v) New hospitals[1] are excluded from the fee and payments;

[1] A new hospital is defined in California Welfare and Institutions Code section 14169.51, subdivision (ai), to mean "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 in accordance with subdivision (d) of Section 14169.61."

(vi) Non-Medi-Cal fee-for-service inpatient days in all other hospitals will be assessed a fee of three hundred forty-six dollars and three cents ($346.03) for subject fiscal year 2019-20, Three hundred sixty-seven dollars and seventy-three cents ($367.73) for subject fiscal year 2020-21 and three hundred fifty- dollars and seven cents ($350.07) for the first two subject fiscal quarters of subject fiscal year 2021-22, per inpatient day;

(vii) Non-Medi-Cal managed care inpatient days in hospitals owned by a managed care organization will be assessed a fee of one hundred sixty-five dollars and thirty-four cents ($165.34) for subject fiscal year 2019-20, one hundred seventy-three dollars and seventy-four cents ($173.74) for subject fiscal year 2020-21 and one hundred eighty-three dollars and eighty-three cents ($183.82) for the first two subject fiscal quarters of subject fiscal year 2021-22, per inpatient day;

(viii) Non-Medi-Cal managed care inpatient days in all other hospitals will be assessed a fee of two hundred ninety-five dollars and twenty-five cents ($295.25) for subject fiscal year 2019-20, three hundred ten dollars and twenty-five cents ($310.25) for subject fiscal year 2020-21 and three hundred twenty-eight dollars and twenty-five cents ($328.25) for the first two subject fiscal quarters of subject fiscal year 2021-22, per inpatient day;

(ix) Medi-Cal managed care inpatient days in hospitals owned by a managed care organization will be assessed a fee of three hundred nine dollars and twenty-six cents ($309.26) for subject fiscal year 2019-20, three hundred twenty-seven dollars and four cents ($327.04) for subject fiscal year 2020-21 and three hundred thirty- dollars and forty cents ($330.40) for the first two subject fiscal quarters of subject fiscal year 2021-22, per inpatient day; and

(x) Medi-Cal fee-for-service and managed care days in all other hospitals and Medi-Cal fee-for-service days in hospitals owned by a managed care organization, will be assessed a fee of five hundred fifty-two dollars and twenty-five cents ($552.25) for subject fiscal year 2019-20, five hundred eighty-four dollars ($584.00) for the subject fiscal year 2020-21 and five hundred ninety dollars ($590.00) for the first two subject fiscal quarters of subject fiscal year 2021-22, per inpatient day.

All fees are based on inpatient days for each hospital's 2016 fiscal year end data. For subject fiscal year 2021-22, the number of inpatient days is halved.

The value for the B1/B2 test is currently 1.0015 percent for the subject fiscal year 2019-20, 1.0012 percent for subject fiscal year 2020-21, and 1.0012 percent for the first two

subject fiscal quarters of subject fiscal year 2021-22. Because the model may require further refinement to account for any claiming at the enhanced Federal Medical Assistance Percentages (FMAP) level made available for “newly eligible” individuals pursuant to the Affordable Care Act and any subsequent hospital status change, California will ensure that the revised model continues to comply with the applicable fee waiver requirements.

For your information, we are setting forth the intended payments to hospitals that will be funded by the Phase 6 hospital fee, which are incorporated into proposed Medi-Cal State Plan Amendments 19-0018 and 19-0019, submitted concurrently to this waiver request. The payment structure is substantially the same as was utilized for the payments that were funded by the previously-approved hospital fees.

Fee-for-Service Payments: there will be seven categories of payment increases to be incorporated into the state plan, as follows:

Inpatient supplements - Three hundred fifty-four dollars and fifty-two cents ($1,354.52) per 2016 calendar year Medi-Cal day for private hospitals for subject fiscal year 2019-20, one thousand, six hundred twenty-two dollars and ninety-seven cents ($1,622.97) per 2016 calendar year Medi-Cal day for private hospitals for subject fiscal year 2020-21 and one thousand, five hundred ninety-two dollars and thirty-one cents ($1,592.31) for half of 2016 calendar year Medi-Cal days for private hospitals for the first two subject fiscal quarters of subject fiscal year 2021-22.

Outpatient supplements - The supplemental payments and other Medi-Cal payments for hospital outpatient services furnished by private hospitals for each fiscal year shall equal as close as possible to the applicable federal upper payment limit. The outpatient supplemental rate shall be 266 percent of the outpatient base amount for the 2019-20 subject fiscal year, 261 percent of the outpatient base amount for the subject fiscal year 2020-21 and 257 percent of the outpatient

base amount for the first two subject fiscal quarters of subject fiscal year 2021-22.

Acute psychiatric supplements - Nine hundred and seventy-five dollars ($975.00) per 2016 calendar year Medi-Cal acute psychiatric day for private hospitals for subject fiscal years 2019-20, 2020-21, and half of 2016 calendar year Medi-Cal acute psychiatric days for the first two subject fiscal quarters of 2021-22.

High Acuity supplements - Two thousand and five hundred dollars ($2,500.00) per 2016 calendar year Medi-Cal high acuity day for qualifying hospitals for subject fiscal years 2019-20, 2020-21, and half of 2016 calendar year Medi-Cal high acuity days for the first two subject fiscal quarters of 2021-22.

Sub-acute supplements - 65 percent of the 2016 calendar year Medi-Cal subacute payments for subject fiscal years 2019-20 and 2020-21, and 65 percent of half of the 2016 calendar year Medi-Cal subacute payments for the first two subject fiscal quarters of 2021-22.

Transplant supplements - The transplant days shall be those identified in the 2016 Patient Discharge file from the Office of Statewide Health Planning and Development accessed on April 2, 2019 for subject fiscal years 2019-20 and 2020-2021, and half of those identified for subject fiscal year 2021-22. The transplant per diem supplemental rate shall be two thousand and five hundred dollars ($2,500.00) for subject fiscal years 2019-20, 2020-21, and for the first two subject fiscal quarters of 2021-22.

Trauma supplements - The trauma per diem supplemental rate shall be two thousand and five hundred dollars ($2,500.00) for subject fiscal years 2019-20, 2020-21, and for the first two subject fiscal quarters of 2021-22. The trauma supplements shall be paid to qualifying

hospitals based on 2016 calendar year Medi-Cal high acuity days for subject fiscal years 2019-20, 2020-21, and half of 2016 calendar year Medi-Cal high acuity days for the first two subject fiscal quarters of 2021-22.

The inpatient, outpatient and acute psychiatric supplements will be paid to all private hospitals, whether or not they are subject to the fee, in the same amount for all Medi-Cal days. The criteria for the high acuity and sub-acute supplements will be paid in manner defined in the proposed Medi-Cal State Plan Amendments 19-0018 and 19-0019, submitted concurrently with this waiver request.

The anticipated amount of total supplements for each category for the 30-month period is as follows:

Inpatient supplements -	$4,793,286,121.80
Outpatient supplements -	$2,432,416,242.57
Acute psychiatric supplements -	$161,904,568.13
High acuity supplements -	$794,318,750.00
Sub-acute supplements -	$224,836,360.00
Transplant supplements -	$69,312,500.00
Trauma supplements -	$329,675,000.00

Managed Care Payments: As in the prior phase, a portion of hospital fee revenue will be used to increase managed care capitation rates during the Phase 6 period, for purposes of enhancing reimbursement for hospital services delivered in Medi-Cal managed care. California, in consultation with hospital and plan partners, is in process of developing the successor payment model(s) to be employed during Phase 6 for purposes of complying with the provisions of 42 CFR §438.6 that are effective July 1, 2017. The amount funded by the fee to be distributed through managed care capitation increases during the Phase 6 period is expected to be twelve billion, eight hundred eighteen million, eight hundred sixteen thousand, one hundred forty-three dollars ($12,818,816,143).

Waiver Justification: We believe the Phase 6 hospital fee proposal satisfies the criteria of the CMS regulations for a waiver under 42 C.F.R. §433.72(b):

- The net impact of the fee and of the payments to be made to hospitals utilizing the revenue generated by the fee is generally redistributive, as demonstrated by the results of the B1/B2 test set forth above.

- The amount of the fee is not directly correlated to Medicaid payments. As before, a substantial number of hospitals that are not subject to the fee will participate in the payment increases funded by the fee. An updated table showing the absence of correlation of hospital fees and Medicaid utilization is included.

- The fee program does not fall within the hold harmless provisions specified in 42 C.F.R. §433.68(f):

    - The State does not provide for any direct or indirect non-Medicaid payment to hospitals paying the fee that is positively correlated with either the fee amount or the difference between the Medicaid payment and the fee amount.

    - No portion of the Medicaid payments varies based only on the amount of the fee paid.

    - There is no direct or indirect guarantee by which the State holds any hospital harmless for all or any portion of the fee amount. The aggregate revenue from the fee will not exceed 6 percent of inpatient net revenues projected for the program period July 1, 2019 through December 31, 2021, based on net revenue received by the hospitals.

We would be pleased to provide any additional information that you require for processing this request. We look forward to your favorable response.

Sincerely,

[redacted]

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Enclosure

cc: See next page

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