



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

March 30, 2017

Ms. Kristin Fan
Director, Financial Management Group
Center for Medicaid, CHIP and Survey & Certification
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Fan:

Re: CALIFORNIA REQUEST FOR WAIVER FOR HOSPITAL FEE - PHASE 5

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 17-004 and 17-005. This next iteration of the hospital fee (which we refer to as the Phase 5 fee) applies to the period January 1, 2017 through June 30, 2019. The terms and conditions for the Phase 5 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 January 1, 2017. The terms of the Phase 5 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 hospitals¹ 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." Pursuant to California

- (vi) Non-Medi-Cal fee-for-service inpatient days in all other hospitals will be assessed a fee of three hundred eighty seven dollars and sixty-two cents (\$387.62) for the last two quarters of the subject fiscal year 2016-17, four hundred thirty-four dollars and eight cents (\$434.08) for subject fiscal year 2017-18 and four hundred seventy-six dollars and sixty-nine cents (\$476.69) for subject fiscal year 2018-19, 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 six dollars and forty cents (\$106.40) for the last two quarters of the subject fiscal year 2016-17, one hundred six dollars and forty cents (\$106.40) for subject fiscal year 2017-18 and one hundred six dollars and forty cents (\$106.40) for subject fiscal year 2018-19, per inpatient day;
- (viii) Non-Medi-Cal managed care inpatient days in all other hospitals will be assessed a fee of one hundred ninety dollars (\$190.00) for the last two quarters of the subject fiscal year 2016-17, one hundred ninety dollars (\$190.00) for subject fiscal year 2017-18 and one hundred ninety dollars (\$190.00) for subject fiscal year 2018-19, per inpatient day;
- (ix) Medi-Cal managed care inpatient days in hospitals owned by a managed care organization will be assessed a fee of two hundred thirty-two dollars and eighty-three cents (\$232.83) for subject fiscal year 2016-17, two hundred forty-nine dollars and seventy-seven cents (\$249.77) for subject fiscal year 2017-18 and two hundred sixty-five dollars and forty-four cents (\$265.44) for subject fiscal year 2018-19, 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 four hundred fifteen dollars and seventy-six cents (\$415.76) for the last two quarters of subject fiscal year 2016-17, four hundred forty-six dollars and one cent (\$446.01) for the subject fiscal year 2017-18 and four hundred seventy-three dollars and ninety-nine cents (\$473.99) for subject fiscal year 2018-19, per inpatient day.

All fees are based on inpatient days for each hospital's 2013 calendar year data.

The value for the B1/B2 test is currently 1.004 percent for the last two subject fiscal quarters of the subject fiscal year 2016-17 and 1.004 percent for subject fiscal year 2017-18 and 1.004 for subject fiscal year 2018-19. Because the model may require further refinement to account for any claiming at the enhanced Federal Medical Assistance

Welfare and Institutions Code section 14169.59, subdivision (g)(5), the hospital described in California Welfare and Institutions Code section 14165.50, subdivision (f)(1), is not to be treated as a "new hospital" for purposes of this request.

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 5 hospital fee, which are incorporated into proposed Medi-Cal State Plan Amendments 17-004 and 17-005, 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 - One thousand one hundred eleven dollars and thirty cents (\$1,111.30) per 2013 calendar year Medi-Cal day for private hospitals for the last two quarters for the subject fiscal year 2016-17, one thousand two hundred twenty-four dollars and eighty-six cents (\$1,224.86) per 2013 calendar year Medi-Cal day for private hospitals for subject fiscal year 2017-18 and one thousand three hundred five dollars and seventeen cents (\$1,305.17) per 2013 calendar year Medi-Cal days for private hospitals for subject fiscal year 2018-19.
- 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 90 percent of the outpatient base amount for the last two subject fiscal quarters in the 2016-17 subject fiscal year, 195 percent of the outpatient base amount for the subject fiscal year 2017-18 and 206 percent of the outpatient base amount for the subject fiscal year 2018-19.
- Acute psychiatric supplements - Nine hundred and seventy-five dollars (\$975.00) per 2013 calendar year Medi-Cal acute psychiatric day for private hospitals for the last two subject

fiscal quarters in the subject fiscal year 2016-17 and for subject fiscal years 2017-18 and 2018-19.

High Acuity supplements - Two thousand and five hundred dollars (\$2,500.00) per 2013 calendar year Medi-Cal high acuity day for qualifying hospitals for the last two subject fiscal quarters in the subject fiscal year 2016-17 and for subject fiscal years 2017-18 and 2018-19.

Sub-acute supplements- 30 percent (half of 60 percent) of the 2013 calendar year Medi-Cal subacute payments for the last two subject fiscal quarters in the subject fiscal year 2016-17 and for 60 percent for subject fiscal years 2017-18 and 2018-19.

Transplant supplements- The transplant days shall be those identified in the 2013 Patient Discharge file from the Office of Statewide Health Planning and Development accessed on December 27, 2013. The transplant per diem supplemental rate shall be two thousand and five hundred dollars (\$2,500.00) for the last two subject fiscal quarters in the subject fiscal year 2016-17 and for subject fiscal years 2017-18 and 2018-19.

Trauma supplements- The trauma per diem supplemental rate shall be two thousand and five hundred dollars (\$2,500.00) for the last two subject fiscal quarters in the 2016-17 subject fiscal year and for subject fiscal years 2017-18 and 2018-19.

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 17-004 and 17-005, 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 - \$ 4,738,669,603.97

Outpatient supplements -	\$ 1,822,653,909.53
Acute psychiatric supplements -	\$ 104,718,909.99
High acuity supplements -	\$ 883,249,603.72
Sub-acute supplements -	\$ 387,549,623.75
Transplant supplements -	\$ 52,056,250.00
Trauma supplements -	\$ 288,206,250.00

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 5 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 5 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 5 period is expected to be nine billion, nine hundred twenty three million, two hundred thirty-seven thousand and forty-six dollars (\$9,923,237,046).

Waiver Justification: We believe the Phase 5 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 forthcoming.
- 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 January 1, 2017 through June 30, 2019, 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.

ORIGINAL SIGNED

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