ENCLOSURE **FOR STAKEHOLDERS ONLY

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

11-025*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	Insert Page(s)
None	Supplement 14 to Attachment 4.19-B Pages 1-5

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

JUN 2 2 2012

Toby Douglas
Director of Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) Number 11-025. This SPA provides for outpatient hospital supplemental payments, funded by a quality assurance fee, for the service period of July 1, 2011 to December 31, 2013.

The effective date of this SPA is July 1, 2011. Enclosed are the following approved SPA pages that should be incorporated into your State Plan:

- Supplement 14 to Attachment 4.19-B pages 1-5

If you have any questions, please contact Kristin Dillon at (415) 744-3579 or at kristin.dillon@cms.hhs.gov.

Sincerely,

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

Cc: Mari Cantwell, California Department of Health Care Services
Kristin Fan, Centers for Medicare and Medicaid Services
Dianne Heffron, Centers for Medicare and Medicaid Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-025

2. STATE: CA

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
July 1, 2011

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~~
75 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT:

a. FFY 11	~~$90,476,093~~	79,291,968
b. FFY 12	~~$562,544,136~~	328,348,086
c. FFY 13	~~$971,223,373~~	366,820,400
d. FFY 14	~~$97,875,795~~	95,403,854

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 14 to Attachment 4-19-B
~~Pages 1-3~~ pages 1-5

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Supplemental Reimbursement for Hospital Outpatient 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:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED:
SEP 20 2011

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 20 2011

18. DATE APPROVED: JUN 22 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Gloria Nagle, Ph.D., MPA

22. TITLE: Associate REgional Administrator
Division of Medicaid & Children's Health Ops

23. REMARKS:

Pen-and-ink changes made to Boxes 7 and 8 by the Regional Office, with email concurrence by the State dated 6/18/2012.

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*** for a hospital which meets specified requirements and provides outpatient services to Medi-Cal beneficiaries.

Supplemental payments to hospitals will be up to the aggregate upper payment limit for the category of hospitals receiving the payments.

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.

This supplemental payment program will be in effect from July 1, 2011, through and including December 31, 2013.

A. Amendment Scope and Authority

This amendment, Supplement 14 to Attachment 4.19-B, describes the payment methodology to provide supplemental payments to eligible hospitals between July 1, 2011, and December 31, 2013. Supplemental payments will be made on a quarterly basis, with a lump sum payment of quarterly payments for quarters ending prior to the approval date of the SPA.

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 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 2009.

    c. Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

d. Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms were defined **on July 1, 2011,** 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 supplement will become ineligible if any of the following occur:

a. The hospital becomes a converted hospital pursuant to paragraph 3 of Section C.

b. The hospital becomes a new hospital.

c. The hospital does not meet all the requirements as set forth in paragraph 1.

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 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 the California Welfare and Institutions Code Section 14132.100.

2. "Outpatient base amount" means the total amount of payments for hospital outpatient services made to a hospital in the 2009 calendar year, as reflected in the state paid claims files prepared by the department on June 2, 2011.

3. "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital on or after July 1, 2011. **(Note: This definition is different from the definition of "converted hospital" as referenced in subparagraph d of paragraph 1 of Section B.)**

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 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.

5. "Program period" means the period from July 1, 2011, through December 31, 2013, inclusive.

6. "Days data source" means the hospital's Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of May 5, 2011, for its fiscal year ending during 2009.

7. "Subject fiscal year" means a state fiscal year that ends after July 1, 2011, and begins before January 1, 2014.

8. "Service period" means the quarter to which the supplemental payment is applied.

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 each subject fiscal year.

2. Except as set forth in paragraphs 6 and 7, each private hospital will be paid an amount for each subject fiscal year equal to a percentage of the hospital's outpatient base amount, ***except for fiscal year 2013-14, in which each private hospital will be paid an amount equal to a percentage of the hospital's outpatient base amount, reduced by 50 percent.***

   a. The percentage will be the same for each hospital for a subject fiscal year. The percentage will result in payments to hospitals that equal the applicable federal upper payment limit, except for the 2011-12 State fiscal year during which the percentage will result in payments to hospitals that equal the applicable federal upper payment limit for the 2011-12 state fiscal year, less any amounts paid pursuant to Supplement 13 to Attachment 4.19-B and accounted toward the applicable federal upper payment limit.

   b. For purposes of this section, the applicable federal upper payment limit will be the federal upper payment limit for hospital outpatient services furnished by private hospitals for each subject fiscal year.

   c. ***The percentage for each subject fiscal year will be derived as follows:***

(1) ***Calculate the difference between the aggregate outpatient hospital payments to private hospitals in the fiscal year of payment (other than as provided for in this section) and the aggregate federal upper payment limit for outpatient hospital services for private hospitals in that year.***

(2) Calculate the percentage that the difference, as determined pursuant to item (i), is to the sum of all hospitals' outpatient base amount. The percentage will be the same for every hospital for a fiscal year.

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 ***$1,739,728,607***, the payments to all hospitals in that fiscal quarter shall be reduced by the applicable percentages so that the aggregate of all supplemental payments to all hospitals does not exceed ***$1,739,728,607***.

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 upper payment limit or for any other reason, both of the following will apply:

   a. The total amount payable to private hospitals under paragraph 2 for the service period will be reduced to the amount for which federal financial participation is available pursuant to subparagraph b.

   b. The amount payable under paragraph 2 to each private hospital for the service period 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 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, 2013 and such carryover payments will not result in total payments exceeding the applicable federal upper payment limit for the service period.

5. The supplemental payment amounts as set forth in this section are inclusive of federal financial participation.

6. No payments will be made pursuant to this supplement to a new hospital.

7. **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 supplement to **that** hospital.