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

Jennifer Kent
Director

EDMUND G. BROWN JR.
Governor

July 20, 2015

Medi-Cal Eligibility Division Information Letter No.: 15-17

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: PROPOSED CHANGES IN THE PAYMENT METHODOLOGY FOR OUT OF STATE "BORDER HOSPITALS"

The purpose of this Medi-Cal Eligibility Division Information letter is to request that counties post the enclosed Public Notice in a prominent location. The information provided in the notice pertains to a policy change with regard to out of state "border hospitals." This policy change will be incorporated into an upcoming State Plan Amendment and is of public interest.

If you have any questions, or if we can provide further information, please contact John Mendoza, Chief of the Safety Net Financing Division at (916) 552-9130 or by email at John.Mendoza@dhcs.ca.gov.

Original Signed By:

Alice Mak, Acting Chief
Medi-Cal Eligibility Division

Enclosure

DEPARTMENT OF HEALTH CARE SERVICES

NOTICE OF GENERAL PUBLIC INTEREST

THE DEPARTMENT OF HEALTH CARE SERVICES PROPOSES TO SUBMIT A STATE PLAN AMENDMENT FOR CHANGES IN THE MEDI-CAL REIMBURSEMENT METHODOLOGY FOR OUT-OF-STATE BORDER HOSPITALS

This notice is to provide information of public interest about proposed changes in the payment methodology for out of state (OOS) "border hospitals," which will be defined as hospitals located outside the State of California that are within fifty-five (55) miles driving distance from the nearest physical location at which a road crosses the California border as defined by the US Geological Survey. The effective date of the State Plan Amendment ("SPA") for the proposed changes will be July 1, 2015. Implementation of these changes is subject to approval of the proposed SPA by the Federal Centers for Medicare & Medicaid Services (CMS).

Senate Bill 853 (Chapter 717, Statutes of 2010) added Section 14105.28 to the Welfare and Institutions Code, which required that the Medi-Cal Fee-for-Service (FFS) acute inpatient reimbursement methodology for private and non-designated public hospitals be changed to one based on diagnosis-related groups. As a result, the Department implemented the All Patient Refined Diagnosis-Related Group (APR-DRG) reimbursement methodology.

Under the APR-DRG methodology, a hospital's reimbursement for a particular patient is based on a wage-adjusted statewide base price, wage-adjusted rural remote base price, or transition base price, and a numeric value for the APR-DRG code for the patient's described condition. The final APR-DRG payment may include the application of payment adjustors, add-on payments and subtraction of other health coverage and other share of cost, as applicable.

Title 42, Code of Federal Regulations, Section 431.52 (b)(4), and Title 22 California Code of Regulations, Section 51006, subdivision (a)(4) recognize that it may be common practice for Medi-Cal recipients residing in some areas of California to obtain medical services in adjacent areas in the states of Oregon, Nevada, and/or Arizona. In recognition of the role that border hospitals may play in providing services to those Medi-Cal beneficiaries, the Department intends to submit a SPA to further align payment standards applicable to California hospitals and OOS border hospitals to the greatest extent reasonably practicable. Specifically, the proposed SPA will provide that in calculating payment for border hospitals under the APR-DRG methodology, the Department will apply:

1) The most recent hospital-specific wage area index values published by CMS and used by the federal Medicare program, adjusted by a budget neutrality factor of 0.9797 which the Department is also proposing to apply to the hospital-specific wage index values for California hospitals beginning July 1, 2015.

2) The rural remote base price if the hospital is defined as a rural hospital by the federal Medicare program and meets the California State Plan definition of “remote”.

3) A Cost-to-Charge (CCR) ratio for determining eligibility to outlier payments that is equal to the unweighted average of the Medicare urban CCR and the Medicare rural CCR, including operating and capital components for the state in which the border hospital is located.

4) The enhanced Neonatal Intensive Care Unit (NICU) policy adjustment for a hospital stay assigned to the neonate care category if the California Children’s Services (CCS) program determines that the hospital qualifies as a Regional NICU pursuant to CCS Manual of Procedures, Chapter 3.25.1, or that it qualifies as a Community NICU pursuant to CCS Manual of Procedures Chapter 3.25.2, and meets CCS standards for neonatal surgery. A border hospital that wishes to qualify for the 1.75 NICU policy adjustments must submit an application to the CCS program in accordance with CCS Manual Chapter 3.25.1 or Chapter 3.25.2.

The Department estimates that these changes will result in an annual increase in Medi-Cal fee-for-service expenditures of approximately $1.4 million annually (federal and state dollars) assuming similar utilization and patients’ casemix as in recent years.

PUBLIC REVIEW AND COMMENTS

Copies of this public notice will be available at welfare offices in every county of the State.

Copies of the State Plan Amendment that amends California’s Medicaid State Plan may be requested, in writing, from Mr. John Mendoza, Department of Health Care Services, Safety Net Financing Division, MS 4518, P.O. Box 997436, Sacramento, CA 95899-7436.

Written comments concerning the proposal may be mailed to Mr. Mendoza at the above address and must be received on or before August 3, 2015.