DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

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

OCT 27 2011

Dear Mr. Douglas:

I am responding to the pending request for reconsideration of the decision to disapprove the California State plan amendments (SPAs) 08-009A; 08-009B1; 08-009B2; 08-009D, which were submitted on September 30, 2008, and SPA 08-019, which was submitted on December 31, 2008. The SPAs proposed to reduce the reimbursement rates for certain services furnished under the approved State plan.

On November 18, 2010, the Centers for Medicare & Medicaid Services (CMS) disapproved these amendments because the State did not provide sufficient information concerning the impact of the proposed reimbursement reductions on beneficiary access to services as required by section 1902(a)(30)(A) of the Social Security Act (the Act). Section 1902(a)(30)(A) of the Act requires that care and services are available to Medicaid beneficiaries at least to the extent that care and services are available to the general population in the geographic area. In addition, CMS was concerned that, given the time that had elapsed since the above SPAs had been submitted, the cumulative effect of approval of and subsequent implementation of these reimbursement reductions would exacerbate beneficiary access concerns. On November 19, 2010, the State requested that CMS reconsider the disapproval of the above amendments.

On March 25, 2011, the State submitted documentation to support a demonstration of compliance with section 1902(a)(30)(A) of the Act, as it specifically relates to reimbursement rates that are sufficient to enlist enough providers so that care and services are available at least to the extent that care and services are available to the general population in the geographic area. From March 25, 2011, through approximately September 30, 2011, CMS has been working with the State to refine the information initially submitted and, as a result of this collaborative process, the State was able to provide metrics that adequately demonstrated beneficiary access. In general, these metrics included data which provided:

- Total number of providers by type and geographic location and participating Medi-Cal providers by type and geographic area
- Total number of Medi-Cal beneficiaries by eligibility type
- Utilization of services by eligibility type over time
- Analysis of benchmark service utilization where available

Data concerning these metrics were submitted for State Fiscal Years (SFYs) 2008, 2009 and 2010.

Based on the analysis described above, the State has requested that CMS approve SPAs 08-009A, 08-009B1, 08-009D. As part of the reconsideration of the above SPAs, the State has modified the SPAs to reflect that the reductions prior to 2011 will only be authorized under the plan in those years, and for those periods, during which the State actually implemented the reduction. This targeting addresses the issue we had raised earlier of retroactively implementing rate cuts which might potentially affect current access. As noted in our original letter denying the 2008 SPAs, recoupment of retroactive reductions might create access problems going forward. The amendments to the 2008 State plan largely resolve this concern for periods prior to 2011.

Because the State implemented some reductions, CMS was able to study the correlation between the reduction to the reimbursement of those services and the change in the above metrics from SFY 2008 – SFY 2010. Based on this analysis, including a period of rate reductions, CMS was able to conclude that the implementation of the above reimbursement reductions complied with section 1902(a)(30)(A) of the Act so that care and services are available at least to the extent that care and services are available to the general population in the geographic area. As modified, the SPAs also implement payment reductions for certain services in 2011. The retroactive implementation of rate cuts for a short time in 2011 is of far less concern than the retroactive implementation of rate cuts for several years. Nevertheless, the State demonstrated beneficiary access for SFY 2010, and also submitted a monitoring plan as part of SPA 08-009B1 by which beneficiary access will be monitored on a service-by-service basis for all the services at issue in these three SPAs. We believe that the proposed monitoring process will allow California to ensure that payment rates for 2011 are consistent with section 1902(a)(30)(A) of the Act or to promptly take corrective action if the rates prove to be insufficient. The State will monitor predetermined metrics on a quarterly or annual basis in order to ensure that beneficiary access is comparable to services available to the general population in the geographic area.

In light of the data CMS reviewed, the monitoring plan, and our consideration of stakeholder input, we have determined that these amendments comply with section 1902(a)(30)(A) of the Act and all other applicable requirements of the Act, therefore, SPAs 08-009A; 08-009B1; 08-009D have been approved, effective July 1, 2008. This approval does not affect SPA 08-009B-2 and SPA 08-019. The State has chosen not to pursue the reductions proposed via SPA 08-009B-2, therefore, we understand that the State will withdraw its formal request for reconsideration of this amendment. With regard to SPA 08-019, the State incorporated the reductions initially proposed via SPA 08-019 into the reductions proposed via SPA 08-009A, therefore, we understand that the State will also withdraw its formal request for reconsideration of SPA 08-019. The revised approved plan pages and the HCFA-179 are enclosed.

If you have any questions, please have your staff contact Dianne Heffron at (410) 786-3247.

Sincerely,

[redacted]

Donald M. Berwick, M.D.

Enclosures

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: 08-009A

2. STATE: California

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, 2008

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-Payment for InatientHospital and Long Term Case

7. FEDERAL BUDGET IMPACT:
a. FFY 2007-08 $(-3.7M) 2009-10 $(-54.9M)
b. FFY 2008-09 $(-69.4M) 2010-11 $(-26.6M)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A amend pages 2 and 5 add pages 3.2-3.4 and 5.1-- 5.5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages 2 and 5

10. SUBJECT OF AMENDMENT:
Payment Reductions for InpatientServicesof Non-contracted Hospitals

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:
[redacted]

13. Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: 10/5/11

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:

18. DATE APPROVED: OCT 27 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2008

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
[redacted]

22. TITLE: DIRECTOR, CMCS

23. R[redacted]

FORM HCFA-179 (07-92)

II. REIMBURSEMENT LIMITS

A. Reimbursement for in-state hospital inpatient services provided to Medi-Cal program beneficiaries for provider fiscal periods beginning on or after May 23, 1992 and not fully covered by a negotiated contract as allowed in the Welfare and Institution Code (W&I) Section 14081, shall be the lowest of the following four items except as stated in B., D., F., G., H., M., and N., for each provider:

1) Customary charges;

2) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 Code of Federal Regulations (CFR), Part 413 and HCFA Publication 15-1.

3) All-inclusive rate per discharge limitation (ARPDL). This is detailed in Section V. of this Plan.

4) The peer grouping rate per discharge limitation (PGRPDL). This is detailed in Section IX. of this Plan.

B. The following adjustment should be made to items 1) through 4) above:

1) Providers shall also be reimbursed for disproportionate share payments if applicable.

2) The least of the four items listed in A. 1) – 4) above shall be reduced by the amount of TPL.

C. Amounts determined under 3) or 4) above may be increased only by an AA or formal appeal.

D. New hospitals and rural hospitals shall be exempt from the provisions of this part of the Plan relating to the MIRL and PIRL. New and rural hospitals shall be reimbursed in accordance with the lessor of A. 1) or A. 2) above, and subject to any limitations provided for under federal law and/or regulation.

M. Noncontract Hospital Inpatient Services: Effective July 1, 2008

(1) In determining reimbursement for a final cost report settlement for a hospital's fiscal period that includes any dates of service on or after July 1, 2008, the reimbursement limitation under paragraph II.A.2 for services on or after that date, shall be 90 percent of the allowable cost per day determined under that paragraph, multiplied by the number of Medi-Cal covered inpatient days on or after July 1, 2008, within the hospital's fiscal period.

(2) The payment limitation provided in paragraph (1) above applies to small and rural hospitals, as defined in Section 124840 of the California Health and Safety Code as of July 1, 2008, for dates of service July 1, 2008, through and including October 31, 2008. For dates of service on or after July 1, 2009, small and rural hospitals will be subject to the payment limitation in subparagraph (1) above.

(3) Hospitals that are certified by Medicare as Medical Critical Access Providers or as Rural Referral Centers are exempt from the payment reductions described in subparagraph (2) for dates of service on and after July 1, 2009.

N. Noncontract Hospital Inpatient Services: Effective October 1, 2008

(1) In determining reimbursement for a final cost report settlement for a hospital's fiscal period that includes dates of service on or after October 1, 2008, the reimbursement limitation under paragraph II.A.2 for inpatient services on or after that date applicable to hospitals not under contract with the California Medical Assistance Commission (CMAC) will not exceed either the limit set forth in paragraph M or the applicable regional average per diem CMAC contract rate for tertiary and other hospitals, reduced by five percent.

(2) Paragraph N(1) does not apply to either of the following:

(i) Small and rural hospitals pursuant to California Health and Safety Code section 124840 as of July 1, 2008.

(ii) Hospitals with licensed general acute care beds located in open health facility planning areas on October 1, 2008, unless the open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area, or the open health facility planning area has three or

more hospitals that are not state-owned with licensed general acute care beds.

(3) The applicable CMAC regional average per diem contract rate, as set forth in paragraph N(1), will be derived from the unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in CMAC's Annual Report to the California Legislature (Annual Report). For tertiary hospitals and for all other hospitals, the regional average per diem contract rates will be based on the geographic regions in CMAC's Annual Report. These rates were published by the Department on or before October 1, 2008, and will be updated annually for each state fiscal year and become effective on the following July 1. Supplemental payments will not be included in this calculation.

(4) The federal and non-federal share of designated public hospital cost-based rates will be included in the determination of the average contract rates by including the total allowable costs that are used for the calculation of the hospital's interim rate that is in effect on June 1 of each year, pursuant to California Welfare and Institutions Code section 14166.4 as of October 5, 2005.

(5) The applicable average per diem contract rates are published annually by the Department, and these rates will be updated annually for each state fiscal year and become effective each July 1, thereafter.

(6) For purposes of this paragraph N, the following definitions apply:

(i) "Tertiary hospital" means a children's hospital as defined in California Welfare and Institutions Code section 10727 as of June 1, 1998, or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Title 22 of the California Code of Regulations sections 100259 – 100260 as of August 12, 1999.

(ii) "Open health facility planning area" (or "open area") and "closed health facility planning area" (or "closed area") have the same meanings and will be applied in the same manner as used by CMAC in the implementation of the hospital

contracting program authorized in California Welfare and Institutions Code sections 14081 et. seq. as of July 1, 2008.

"Open areas" are those health facility planning areas where there are no or insufficient SPCP contracting hospitals to provide Medi-Cal inpatient services. A Medi-Cal beneficiary may receive inpatient services in any hospital in an open area. The California Medical Assistance Commission determines whether a health facility planning area is open or closed.

"Closed areas" are those health facility planning areas where: (1) SPCP contracts for sufficient beds for required services have been negotiated; (2) Medi-Cal beneficiaries must receive inpatient services at a contract hospital, and (3) emergency services may be provided in a non-contract hospital only until the patient is stabilized for transfer to a SPCP contract hospital under Welfare and Institutions Code section 14087 as of July 1, 2008 in order to direct inpatient services to SPCP contracting hospitals.

provider for which the rate is needed, the Department will base an interim rate of payment on the reimbursable costs and customary charges of the comparable provider.

2. If there are no substantially comparable providers from whom data are available, the Department will determine an interim rate of payment based on the budgeted or projected reimbursable costs and customary charges of the provider.

3. Under either method, the Department will review the provider's cost and charge experience and adjust the interim rate of payment in line with the provider's cost and charge experience.

4. The Department may prohibit increases in the accommodation rates, as defined in applicable parts of 42 CFR, Part 413 and HCFA Publication 15 – 1, charged by the provider if the Department projects that such increases would cause their interim payments to exceed the PIRL.

5. Newly established providers may appeal their interim rate if it is based upon the criteria in A. 2) (c) 1. through 4, in accordance with the AAR procedures specified in Section VI. of this Plan.

(d) For dates of service on or after July 1, 2008, interim payments that would otherwise be made based on the interim rate established in accordance with this paragraph will be reduced by ten percent. Hospitals that are certified by Medicare as Medical Critical Access Providers or as Rural Referral Centers are exempt from the payment reductions for dates of service on or after November 1, 2008 as specified in this paragraph (d). Other small and rural hospitals are exempt from the payment reduction during the period November 1, 2008 through June 30, 2009.

(e)(1) Notwithstanding paragraph (d), for dates of service on or after October 1, 2008, interim payments that would otherwise be made based on the interim rate established in accordance with this paragraph III for inpatient hospital services will not exceed the applicable regional average per diem California Medical Assistance Commission (CMAC) contract rate for tertiary and other hospitals, reduced by five percent.

(2) For purposes of this paragraph (e), the term "tertiary hospital" means as defined in paragraph II.N(6), above.

(3) Paragraph (e)(1) does not apply to either of the following:

(I) Small and rural hospitals, as defined in California Health and Safety Code section 124840 as of July 1, 2008.

(II) Hospitals with licensed general acute care beds located in open health facility planning areas on October 1, 2008, unless the open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area, or the open health facility planning area has three or more hospitals (that are not state-owned) with licensed general acute care beds. As used in this subparagraph, the terms "open health facility planning area" and "closed health facility planning area" have the same meanings as defined in Paragraph II.N(6), above.

(4) The applicable CMAC regional average per diem contract rate will be derived from the unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in CMAC's Annual Report to the Legislature (Annual Report). For tertiary hospitals and for all other hospitals, the regional average per diem contract rates will be based on the geographic regions in CMAC's Annual Report. These rates were published by the Department on or before October 1, 2008, and will be updated annually for each state fiscal year and become effective on the following July 1. Supplemental payments will not be included in this calculation.

(5) The federal and non-federal share of designated public hospital cost-based rates will be included in the determination of the average contract rates by including the total allowable costs that are used for the calculation of the hospital's interim rate that is in effect on June 1 of each year, established pursuant to California Welfare and Institutions Code section 14166.4 as of October 5, 2005.

(6) The applicable average per diem contract rates were published by the Department on or before October 1, 2008, and these rates will be updated annually for each state fiscal year and become effective each July 1, thereafter.

(f) The hospitals and hospital groups listed below are reimbursed at reduced payments based on the particular reductions in effect for the specified time periods. The reductions in Sections II.M, II.N, III.A.2.d, and III.A.2.e of this Attachment 4.19–A are only applied to the following hospitals for the following specified periods.

1. Non-Contract Hospitals (17 Hospitals and Hospital Groups - Santa Rosa Memorial Hospital, Petaluma Valley Hospital, Queen Of The Valley Hospital - Napa, St. Helena Hospital, John Muir Medical Center, Central Valley General Hospital, San Joaquin Community Hospital, Bakersfield Heart Hospital, Lancaster Community Hospital, AHMC Anaheim Regional Medical Center, LP (Anaheim Memorial Medical Center), Orange Coast Memorial Medical Center, Fountain Valley Regional Hospital Medical Center, Hoag Memorial Hospital Presbyterian, Mission Hospital Regional Med Center, Saddleback Memorial Med Center - Laguna Hills, Children's Hospital At Mission, and San Antonio Community Hospital)

Period in Effect	Reduction Type	Description of the Reductions
07/01/08 - 09/30/08	10%	The hospitals and hospital groups identified above are subject to the ten percent payment reduction.
10/01/08 - 04/05/09	10%; limit at average CMAC rate minus 5%	The hospitals and hospital groups identified above are subject to the CMAC minus five percent rate reduction, until 4/5/2009.
04/06/09 - 11/17/09	10%	The hospitals and hospital groups identified above are subject to the ten percent payment reduction until 11/17/2009.
01/01/11 - 04/12/11	10%; limit at average CMAC rate minus 5%	SB 90 (2011) ended the hospital inpatient payment reductions effective 4/13/2011.

2. Non-Contract Hospitals (Other than the hospitals identified in paragraph 1 above and those hospital categories below)

Period in Effect	Reduction Type	Description of the Reductions
07/01/08 - 09/30/08	10%	All non-contract hospitals are subject to the ten percent payment reduction.
10/01/08-04/05/09	10%; limit at average CMAC rate minus 5%	All non-contract hospitals in closed Health Facility Planning Areas (HFPAs) and non-contract hospitals in open HFPAs with at least 3 hospitals are subject to the CMAC minus five percent rate reduction, until 4/5/2009.
04/06/09 - 12/31/2010	10%	All non-contract hospitals are subject to the ten percent payment reduction.
01/01/11 - 04/12/11	10%; limit at average CMAC rate minus 5%	SB 90 (2011) ended the hospital inpatient payment reductions effective 4/13/2011.

3. Small & Rural (Critical Access Hospitals [CAHs] & Federal Rural Referral Centers [RRCs])

Period in Effect	Reduction Type	Description of the Reductions
07/01/08-10/31/08	10%	All non-contract small and rural hospitals that are Critical Access Hospitals (CAHs) and federal Rural Referral Centers (RRCs) are subject to the ten percent payment reduction.

4. Small & Rural Hospitals (non-CAHs and non-federal RRCs)

Period in Effect	Reduction Type	Description of the Reductions
07/01/08 -10/31/08	10%	All non-contract small and rural hospitals that are not Critical Access Hospitals or not federal Rural Referral Centers are subject to the ten percent payment reduction.
07/01/09 - 02/23/10	10%	All non-contract small and rural hospitals that are not Critical Access Hospitals or not federal Rural Referral Centers are subject to the ten percent payment until 2/23/2010.
1/1/11 – 4/12/11	10%	SB 90 (2011) ended the hospital inpatient payment reductions effective 4/13/2011.

5. Non-contract hospitals in an Open Health Facility Planning Area that were Open Health Facility Planning Areas on October 1, 2008, which has less than three hospitals (that are not state-owned) with licensed acute care beds, but that Open Health Facility Planning Area cannot be a Closed Health Facility Planning Area at any time on or after July 1, 2005

Period in Effect	Reduction Type	Description of the Reductions
07/01/08-04/12/11	10%	SB 90 (2011) ended the hospital inpatient payment reductions effective 4/13/2011.

(g) The payment reductions in the previous section(s) will be monitored in accordance with the monitoring plan at Attachment 4.19-F.

IV. OVERPAYMENTS

A. Interim payment rate adjustments and recovery of overpayments to providers shall be made at tentative or final settlement based upon the application of this plan.

1) Such overpayments shall be collected and such interim payment rates shall be adjusted whether or not appeals of any audit, MIRL or PIRL for the current or any prior fiscal period have been filed by the provider.

2) Interim payment rates calculated after May 23, 1992 for Sections I. through XIII. of this Plan and applied to services provided after May 23, 1992, shall comply with Sections III. and IV. of this Plan even if the actual settlement upon which the new interim rate is based, is not subject to the Plan.