DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

OCT 20 2011

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

RE: California State Plan Amendment TN: 10-026

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-026. This amendment, effective January 1, 2011, provides for supplemental payments, funded by intergovernmental transfers, to governmental hospitals for inpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 10-026 is approved effective January 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Mark Wong at (415) 744-3561.

Sincerely,

[redacted]

Cindy Mann
Director, CMCS

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: **10-026**

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
~~10/1/10~~ 1/1/2011

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 United States Code Section 1396(a)(30)(A) 42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 10/11 ~~$31,886,808~~ $27,254,000
b. FFY 11/12 ~~$40,000,000~~ $35,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 2 to Attachment 4-19-A, page 1, 2, 3, 4, 5, and 6

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT:
Intergovernmental Transfers for Payments to Specified 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. TYPED NAME:
Toby Douglas

14. TITLE:
Chief Deputy Director

15. DATE SUBMITTED: 12-22-10

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.4001
MS 4612 P.O. Box 997413
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: OCT 20 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Penny Thompson

TITLE: Deputy Director, CMCS

23. REMARKS:
Pen-and-ink changes made to Boxes 4, 6, 7, and 8 by Regional Office with State concurrence.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

SUPPLEMENTAL REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

This Program provides supplemental reimbursement for Medicaid fee-for-service (FFS) inpatient hospital services on an annual basis. Hospitals operated by a Government Entity, except those defined in Appendix 1 to Attachment 4.19-A, are qualified for participating in this voluntary program.

A Governmental Entity is defined as a State, city, county, city/county, health care district, or other governmental unit in the State. The hospital receiving payment must retain the full amount of the total payment, and may not return any portion of the payment to any Governmental Entity.

Payment methodology for government-operated hospitals:

The total inpatient hospital Medicaid FFS upper payment limit (UPL) room available for these governmental hospitals (i.e., non-designated public hospitals, which exclude those hospitals in Appendix 1) for the State fiscal year is allocated to two payment pools: one for hospitals contracted with the California Medical Assistance Commission (CMAC); and one for non-CMAC-contracted hospitals. The allocation is made based on the ratio of Medi-Cal fee-for-service acute patient days reflected in the most recent Office of Statewide Health Planning and Development (OSHPD) Annual Financial Disclosure Reports. Each non-designated public hospital's contracting status will determine from which pool it receives funding.

Within each payment pool, each non-designated public hospital will then earn "points" determined by four criteria:

- If a hospital provides services in either a federally recognized Health Professional Shortage Area or to a federally recognized Medically Underserved Area or Population, or if the hospital is federally recognized as either a Critical Access Hospital or a Sole Community Provider, the hospital shall score one point. Otherwise the score shall be zero.

- The hospital will earn points for the amount of charity care provided according to the following formula, using the most recent OSHPD reports:
  - For charity charges greater than or equal to 3 percent of total gross revenue, the points shall be three.
  - For charity charges less than 3 percent but more than or equal to 1 percent of gross revenue, the points shall be two.

- For charity charges less than 1 percent but greater than 0 percent of total gross revenue, the points shall be one.
- For charity charges less than or equal to 0 percent of total gross revenue, the points shall be zero.

- The hospital will earn points for the amount of bad-debt charges incurred as a percent of the hospital's other payer's gross revenue according to the following formula, using the most recent OSHPD reports:
  - If bad-debt charges are greater than or equal to 40 percent of the "other" gross revenue, the hospital shall score two points.
  - If the bad-debt charges are less than 40 percent but greater than 0 percent of the "other" gross revenue, the hospital shall score one point.
  - If the bad-debt charges are less than or equal to 0 percent of "other" gross revenue, the hospital shall score zero points.

- Each hospital will earn points for the volume of Medi-Cal services provided, using the following formula using Medi-Cal charges compared to total gross revenue from the most recent OSHPD reports:
  - If Medi-Cal charges are greater than or equal to 25 percent, the hospital will score three points.
  - If Medi-Cal charges are less than 25 percent but more than or equal to 12 percent, the hospital shall score two points.
  - If Medi-Cal charges are less than 12 percent but greater than 0 percent, the hospital shall score one point.
  - If Medi-Cal charges are less than or equal to 0 percent, the hospital will score zero points.

The sum of the points generated from the above described criteria will equal the hospital's "formula score." The formula score will determine the amount of preliminary allocation from the applicable payment pool:

Formula Group	Contracted Pool Range Score	Non-Contracted Pool Range Score
formula score = 0	no allocation	no allocation
formula score = 7 – 9	3	3
formula score = 4 – 6	2	2
formula score = 1 – 3	1	1

The preliminary allocation to each hospital using the range score is as follows: Within each pool, the ratio of the hospital's range score divided by the sum of the range scores of all hospitals in the pool is applied to the pool's allocated payment amount.

The preliminary allocation amount for each hospital will then be further reallocated within each formula group based on the ratio of each hospital's staffed acute beds to the total staffed acute beds of all hospitals in that formula group — using the most recent OSHPD annual report (2008 report is used for the fiscal year 2010-11 allocation). The ratio is applied to the sum of the preliminary allocation amounts of all hospitals in the formula group.

Timeline:

For the period ending June 30, 2011, the total supplemental payment amount is determined using the UPL for services from January 1, 2011 to June 30, 2011. The supplemental payments will be paid in one installment upon approval of this SPA.

For subsequent State fiscal years, the total supplemental payment amount is determined using the UPL for services for the respective State fiscal year.

By August 1 of each fiscal year, DHCS will determine the amount of UPL room available. Using the UPL room, DHCS will estimate the amount of allocation and supplemental fee-for-service payments that can be made for the fiscal year.

By September 1, 2011, and each fiscal year thereafter, DHCS will provide each non-designated public hospital with an estimated allocation notice that includes the calculations and data sources used.

Each non-designated public hospital will have 30 days from the receipt of the estimated allocation notices to review the calculation and the data, and inform DHCS of any errors.

By November 30 of each fiscal year, DHCS will make any necessary corrections to the data, recalculate the allocations, and provide the non-designated public hospitals with the new amounts by December 1 of each year.

Twenty days from receiving the final allocation offer from DHCS, the hospitals must accept or decline the offer to participate in the supplemental payment program for that fiscal year. Hospitals must affirmatively accept the offer — any non-responders will be considered declined.

By December 31, 2011, and by January 15 of each state fiscal year thereafter, DHCS will document the accepted or declined participating hospitals and, if needed, will allocate any remaining unsubscribed allocations to the participating hospitals on a pro-rata basis using the final allocation amounts.

By January 30 of each fiscal year, each participating hospital will receive a revised final allocation offer from DHCS and will once again be required to accept or decline the offer to participate in the program. The hospital must accept or decline within five days of receiving the revised final allocation offer.

In the last quarter of each fiscal year, DHCS will make the supplemental payment to the non-designated public hospitals, including the associated federal financial participation.

Inpatient Upper Payment Limit Methodology:

The Inpatient UPL room is calculated in three steps: (1) for each hospital, determine the projected Medicare Payment to Charge Ratio (PCR) for the applicable UPL period; (2) for each hospital, apply the PCR to the hospital's projected Medi-Cal FFS inpatient hospital charges for the UPL period to calculate what Medicare would pay for the Medi-Cal FFS inpatient hospital services under Medicare payment principles; the aggregate of what Medicare would pay for all the non-State government operated hospitals is the non-State government operated hospital inpatient UPL; and (3) compare the projected Medi-Cal payments for Medi-Cal FFS inpatient hospital services, including all base and supplemental/enhanced payments, for the UPL period to the UPL - the amount by which the UPL exceeds the aggregate projected payments is the UPL room.

For each step the model applies a trend to the available data to project what the values will be in the target UPL period. The UPL formula is as follows:

Projected Individual IP Hospital Medicare PCR	times	Individual Hospital Projected IP Medi-Cal Charges	Summed for all hospitals equals	Medi-Cal IP Upper Payment Limit

To ensure that total inpatient (IP) payments do not exceed the UPL, a projection is made of total IP Medi-Cal payments for the UPL period. This total is then compared to the IP UPL.

The data elements and assumptions used are as follows:

1. Projected Individual IP Hospital Medicare PCR
Selected Medicare cost report data for all hospitals is obtained from the Hospital Cost Report Information System database for the four most recently available periods. IP Medicare Charges and Payments for each of the four periods are identified and summed for each hospital, including subprovider data but excluding non-hospital data (such as hospital-based long term care data). Primary payer payments and deductible and coinsurance amounts billed to beneficiaries are included in the tabulation of Medicare inpatient payments. Reimbursement amounts related to bad debts are excluded from the payment amounts.

A payment/charge ratio (PCR) is calculated for each hospital for each of the four years. Projected PCRs for target UPL periods are then calculated for each hospital, and vary depending upon the completeness of a hospital's data.

To illustrate how the projected PCRs are calculated: The most recently available Medicare data periods were 2005, 2006, 2007, and 2008. The PCR for Hospitals with complete data for all four periods was projected for CY09 by calculating the average change in a hospital's PCR from 2005-2006, 2006-2007 and 2007-2008 and applying the average of the three changes to the 2008 PCR. The PCR for CY10 was projected in the same manner, but instead the PCRs from 2006, 2007, 2008, and the CY09 projected PCR were used to project the CY10 amount. Similarly, the CY11 was projected using the most recent three data changes. For hospitals with only two or three years of data, only the change between those two or three years was applied to the most recent PCR. If only one data point was available, no trending was applied and that amount was used as the PCR for CYs 09, 10 and 11. To calculate the PCR applicable to the three state fiscal year UPL periods, an average was calculated of the PCR calculated for the two overlapping data years. For example, the PCR for the State fiscal year 2008-09 UPL was calculated by averaging the CY2008 with the CY2009 PCR projection. This approach ensured that the FY2008-09 projection incorporated only half a year trend from CY08 data.

Prospective UPL room calculations will follow this methodology but will use the updated Medicare data from the most recently available periods.

2. Individual Hospital Projected IP Medi-Cal Charges

Each hospital's projected Medi-Cal FFS inpatient hospital charges for the target UPL periods are calculated by applying the average change over four years to the charges from the last period for which there is complete Medi-Cal inpatient hospital claims data.

Individual Medi-Cal inpatient charge projections are varied depending upon the completeness of a hospital's data, using the same projection methodology as that applied to the Medicare PCRs.

To illustrate how the projected Medi-Cal charges are calculated: The latest four periods with complete Medi-Cal inpatient claims data were CY 2005 to CY 2008. The inpatient charges for hospitals with complete data for all four paid claims data periods were projected for CY 09 by calculating the average change in a hospital's inpatient charges from CY05-CY06, CY06-CY07, and CY07-CY08 , and applying the average of the three changes to the CY08 data. The inpatient charges for CY10 were projected in the same manner, but instead the change in the inpatient charges from CY06-CY07, CY07-CY08 and the change from CY08 to the CY09 projected charges were used to project the CY10 amount. CY11 charges were projected in the same manner, using the four most recent calendar year sets of data and projections. For hospitals with only two or three years of data, only the average change between those two or three years was applied to the most recent inpatient charge amount. If only one data point was available, no trending was applied and that amount was used as the inpatient charges for CYs 09, 10 and 11. To project inpatient charge amounts for State fiscal years as the UPL periods, the CY08 data was averaged with

the CY09 projection to estimate the SFY0809 inpatient charges; CY09 and CY10 data were averaged to estimate SFY0910; and CY10 and CY11 were averaged to estimate SFY1011. This approach ensured that the SFY2008-09 projection incorporated only half a year trend from the CY08 data.

Prospective UPL room calculations will follow this methodology but will use the updated Medi-Cal charge data from the most recently available periods.

3. Medi-Cal IP Hospital Payments

Each hospital's projected Medi-Cal FFS inpatient hospital payments for the target UPL periods are determined by applying trend rates to its Medi-Cal FFS inpatient hospital payment amount from the most recent period for which there is complete claims data.

Prior to applying the trend rate, the hospital's Medi-Cal FFS inpatient hospital payment amount, which represents net Medi-Cal payments, is grossed up by an adjustment factor to account for any third party or patient payments. This is necessary since the Medicare payments used to compute the UPL are inclusive of third party and patient payments.

Trend rates are determined separately for hospitals with inpatient contracts negotiated by the California Medical Assistance Commission (CMAC) and for those non-CMAC-contracted hospitals. For the non-CMAC-contracted hospitals as a group, the trend rate for each period is computed using the average payment change over the four most recent periods. For contracting hospitals as a group, the trend rate is computed using a combination of the average CMAC contracting per diem rate change over the four most recent periods and the Medi-Cal day change over the prior period.

The Medi-Cal payments that are measured against the UPL to determine the UPL room, in addition to the base payments, must also include all supplemental and enhanced payments made to the hospitals for Medi-Cal FFS inpatient hospital services.