No. 09-958

In the Supreme Court of the United States

DAVID MAXWELL-JOLLY, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA,

Petitioner,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., A NONPROFIT CORPORATION, et al.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

SUPPLEMENTAL BRIEF FOR PETITIONER

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California's Medicaid program has lost over a billion dollars due to court injunctions over the last three years, including over half a billion dollars due to the decisions at issue in this petition. The United States admits that the Ninth Circuit has incorrectly construed 42 U.S.C. § 1396a(a)(30)(A)'s requirements, and it acknowledges that private parties may lack a cause of action to enforce this statute.

The United States recommends, nonetheless, that the Court leave these issues alone, based in large part on its announcement in its invitation brief that the Department of Health and Human Services (HHS) intends to engage in rulemaking 43 years after § 1396a(a)(30)(A) was enacted and 13 years after the Ninth Circuit announced its first atextual requirements. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998). However, any future rulemaking will exacerbate rather than solve the problems addressed in the petition, as any new rules may simply become fodder for new Supremacy Clause lawsuits. Moreover, the national Medicaid program will continue to suffer, as such lawsuits create the potential for more inconsistent obligations (states in the Ninth Circuit already are subject to numerous obligations that apply nowhere else), exactly what Congress sought to avoid by vesting enforcement in HHS.

The Solicitor General's remaining arguments may be addressed by holding the present petition and granting one of two separately pending petitions that raise substantially the same questions presented:

Maxwell-Jolly v. California Pharmacists Association, No. 09-1158 and *Maxwell-Jolly v. Santa Rosa Memorial Hospital*, No. 10-283.

I. The Court should grant the petition to consider whether private parties may sue under the Supremacy Clause to enforce § 1396a(a)(30)(A)

1. The Solicitor General recognizes that the Ninth Circuit's Supremacy Clause holdings are fundamentally flawed to the extent that they fail to recognize the "analytical[ ] distinct[ion]" between subject matter jurisdiction and the existence of a cause of action. U.S. Br. 14. The Solicitor General does not address how the Supremacy Clause could create a cause of action to enforce § 1396a(a)(30)(A) given that (1) § 1396a(a)(30)(A) does not confer any rights on private parties; (2) this Court has previously held that the Supremacy Clause does not create any rights, *see* Pet. 18-20; and (3) Congress intended to preclude suits challenging the adequacy of Medicaid rates (as reflected in its repeal of the Boren Amendment), and instead to let such issues be resolved administratively (as confirmed by the text and structure of § 1396a(a)(30)(A)). Nor does the Solicitor General try to explain how a provision that is too vague and amorphous to be judicially enforced under § 1983 nonetheless could be judicially enforced under a preemption theory.

2. The Solicitor General opposes review because he contends there is no circuit split. Regardless of whether a split exists, sufficient circuits have now weighed in – and misconstrued this Court's precedent as having already decided the issue – to create a mature issue. Pet. 24-25. The Solicitor General confirms as much, noting that the Ninth Circuit professed to "join several other circuits," including the First, Second, Fifth, Eighth, and Tenth Circuits, in holding that the Supremacy Clause may create a cause of action in the absence of a statutory right. U.S. Br. at 13, 16. There is no reason to wait for more circuits to weigh in, given that the underlying error – misreading of this Court's own precedent – is one that only this Court can correct.

3. The Solicitor General argues for deferring review because "HHS has committed to conducting a rule-making process that will result in an authoritative interpretation of Section 1396a(a)(30)(A) in the coming year." U.S. Br. 20. This new information, coming 43 years after § 1396a(a)(30)(A) was enacted, 30 years after it was last amended, 13 years after *Orthopaedic* was decided, and more than two years after the Ninth Circuit recognized a Supremacy Clause-based cause of action, offers too little, too late.

Any future rulemaking will not, and legally *cannot*, resolve the question of *who may sue* to enforce Medicaid Act requirements. Federal agencies cannot create, or eliminate, causes of action, as only Congress has that power. *Alexander v. Sandoval*, 532 U.S. 275 (2001); *see also Adams Fruit Co. v. Barrett*, 494

U.S. 638, 650 (1990) (where Congress expressly created a private right of action, "it would be inappropriate to consult executive interpretations of [the statute's private-right-of-action provision] to resolve ambiguities surrounding the scope of [the statute's] judicially enforceable remedy"). Future rulemaking will, however, exacerbate the problem unless this Court acts. So long as private suits are allowed, any new rules that HHS promulgates will become fodder for *more* private lawsuits seeking to enforce the new rules.

Finally, in 1997, the Solicitor General recommended against this Court's review of *Orthopaedic* based on a similarly optimistic prediction that, with the benefit of HHS's interpretation of § 1396a(a)(30)(A) as set forth in its invitation brief, and this Court's decision in *Blessing v. Freestone*, 520 U.S. 329 (1997), the lower courts might resolve these problems on their own. Brief for the United States as Amicus at 17-20, *Belshe v. Orthopaedic Hosp.*, No. 96-1742 (S. Ct. Nov. 26, 1997) (*Orthopaedic* Brief). Yet, 13 years later, despite this prediction, this Court's intervening decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and the Ninth Circuit's own decision in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit continues to recognize private suits, and to hew to (and expand upon) its prior, erroneous interpretation.

4. That HHS chose to deny all of the State's long-pending State Plan Amendments (SPAs) two weeks before the United States filed its invitation

brief is irrelevant.[1] Whether private suits should be permitted to proceed, in contravention of Congressional intent that § 1396a(a)(30)(A) be enforced administratively, remains a live question here, in *California Pharmacists*, and *Santa Rosa*. California's administrative appeals remain pending, and HHS's ongoing review of the SPAs demonstrates how Congress intended for the system to work. *See* 42 U.S.C. §§ 1316, 1396c.

Private suits can substantially disrupt that administrative enforcement system, and have done so here. Such suits can result in conflicting obligations on the states, and cost the states and the federal government money, a point the Solicitor General previously acknowledged. *See Orthopaedic* Brief, *supra*, at 16-17. Here, but for the court injunctions, the rate reductions at issue in *California Pharmacists* and *Santa Rosa* would *still be in effect* while CMS

[1] The Solicitor General may lack complete information regarding California's extensive submissions to the Centers for Medicare & Medicaid Services (CMS). U.S. Br. 7. The Department of Health Care Services (DHCS) submitted hundreds of pages of documents and data to CMS in response to pending Requests for Information on July 31, 2009, and was prepared to submit more when CMS advised that the existing materials would suffice "at this time." DHCS submitted additional information on August 9, 2010, and September 3, 2010. Supp. App. 1, 9. DHCS was preparing additional materials when it received HHS's letter advising that all the SPAs had been rejected largely due to the passage of time, even though the SPAs had been taken "off the clock" several months earlier. U.S. Br. App. 2a-3a.

review continues.[2] Injunctions also hurt the state's position when administrative proceedings conclude. For example, if CMS ultimately approves some or all of the SPAs, California will have paid more in reimbursements than it should have, pursuant to injunctions that conflict with CMS's interpretations.

If the recent SPA denials still remain of concern, however, the Court can simply grant review in *California Pharmacists,* where one of the four appeals at issue (*Dominguez*) is not subject to SPA approval because rates continue to be determined pursuant to procedures set forth in an HHS-approved state plan (i.e., collective bargaining between counties and the unions).

5. The Solicitor General's remaining arguments are easily addressed. He suggests that private enforcement may be justified because of "the role private parties can and often do play in vindicating federal law." U.S. Br. 19. But any supplemental

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[2] The AB5 reductions at issue in the present case have sunsetted. However, the AB5 and AB1183 reductions in the *California Pharmacists* and *Santa Rosa* petitions would be fully effective but for the injunctions. In October 2010, the state legislature temporarily suspended the statute at issue in *Dominguez* (SB6) (one of four appeals consolidated in the *California Pharmacists* petition) in contemplation of the courts' review of the issues presented here. *See* Cal. Welf. & Inst. Code § 12306.1(d)(7)(A) (as amended by AB1612) ("temporarily suspend[ing SB6] . . . until July 1, 2012, to allow the litigation to reach a final result" and "[t]o avoid confusion for providers, recipients, and other stakeholders").

enforcement benefits are irrelevant where, as here, Congress did not intend for private enforcement.

The United States made this point itself last month, in arguing that private suits should not be permitted to enforce pharmaceutical companies' Medicaid obligations. Brief for the United States as Amicus Curiae Supporting Petitioners at 32, *Astra USA, Inc. v. Santa Clara County*, No. 09-1273 (S. Ct. Nov. 19, 2010). There, the United States argued that permitting private enforcement suits against drug companies would conflict with congressional intent,[3] undermine the centralized administrative enforcement scheme that Congress created,[4] and result in conflicting court decisions causing further enforcement problems.[5] Of course, these are exactly the arguments that petitioner is making here.

Finally, the Solicitor General suggests that this petition may not be the best vehicle because the underlying lawsuit originated in state court as a petition for mandamus. U.S. Br. 13 n.5. However,

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[3] *Id.* at 23-24 ("[P]ermitting such a suit would have the effect of allowing third parties to circumvent Congress's decision not to permit private enforcement of the statute.").

[4] *Id.* at 11 (provisions of the Medicaid Act "reflect[ ] Congress's intent that HHS should be permitted to determine the manufacturer's obligations in the first instance, in light of its expertise in, and responsibility for, both programs").

[5] *Id.* at 34 ("HHS cannot reasonably participate in every suit that might be filed, and so the potential for conflicting obligations imposed by adjudication without the benefit of HHS's participation or expertise is quite high.").

mandamus is a form of relief rather than a cause of action, and the Ninth Circuit expressly held that the *cause of action* in the present case arose under the Supremacy Clause. Pet. App. 6 & 8 n.7 (citing *Indep. Living Ctr. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008)). But once again, the Court may avoid the issue by granting review in *California Pharmacists* or *Santa Rosa*, which the Solicitor General acknowledges involve cases brought "directly under the Supremacy Clause."

II. The Court should grant the petition to consider whether state Medicaid reforms may be enjoined based on atextual requirements.

1. The Solicitor General agrees that the Ninth Circuit's interpretation of § 1396a(a)(30)(A) is erroneous and conflicts with congressional intent to give states "wide discretion" in setting Medicaid payments. U.S. Br. 7, 9. Further, he acknowledges that "the Ninth Circuit stands alone in requiring States to adopt a particular cost-based methodology to set Medicaid rates" in advance of every rate modification, *id.* at 9-10, and that a circuit split exists on whether § 1396a(a)(30)(A) imposes any procedural requirements. That circuit split recently deepened even further. *See Conn. Ass'n of Healthcare Facs. v. Rell*, No. 10-2237-CV, 2010 WL 3894794 (2d Cir. Oct. 6, 2010) (rejecting that § 1396a(a)(30)(A) imposes a "procedural requirement").

2. In opposing review nonetheless, the Solicitor General mischaracterizes the question before the Court. It is not limited to the Ninth Circuit error on whether states must rely on "responsible cost studies" in setting Medicaid rates or "consider" certain statutory factors. U.S. Br. (I). Rather, the petition questions the Ninth Circuit's practice of enjoining state conduct based on an ever-expanding series of judicially created, atextual criteria, in derogation of the principles set forth in *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981).

The cost-study requirement became merely the first in that series, when it was announced in *Orthopaedic*. In the subsequent decisions at issue in the three pending petitions, the Ninth Circuit added requirements addressing, *inter alia*, (1) *when* any study must be conducted (i.e., pre-enactment *and* pre-implementation); (2) *who* must conduct the study (at least some, and possibly all, members of the state legislature, at least in some cases); (3) *how much documentation* of the study is required (we now know that a notation in a legislative committee agenda does not suffice, although what does is not clear); and (4) and what magic words the study must include to pass muster (e.g., it must specifically reference the reduction and the § 1396a(a)(30)(A) factors). While only some of these issues are implicated in the present petition, the full panoply is implicated in *California Pharmacists,* and largely also in *Santa Rosa*.

3. Thus, HHS's announcement that it plans to engage in future rulemaking to clarify § 1396a(a)(30)(A)

is irrelevant, as the problem is not any discrete rule, but the Ninth Circuit's atextual approach. Rulemaking cannot solve the *Pennhurst* problem, but will only exacerbate it, as any new rules become the engine for new, judicially-created requirements, and subsequent injunctions. An agency cannot anticipate every scenario. Say, for example, HHS promulgates a new regulation requiring that a study be done, but does not identify specifically the type of data that may suffice, or which state official(s) must review it. Under the Ninth Circuit's approach, such regulatory gaps become the basis for future injunctions premised on purportedly clarifying legal rulings that impose new obligations on the states. While HHS is powerless to address this *Pennhurst* problem, this Court is not, and unless it does, injunctions will continue to issue and the substantial problems discussed in the three pending petitions will persist.

Any rulemaking will not be sufficiently timely or comprehensive to provide the States, the courts, and the parties with the clarity they need. The rulemaking process is lengthy, sometimes taking up to decade[6] – cold comfort for a state currently losing over $40 million each month to legally-misguided injunctions. Dozens more cases are pending nationwide in which plaintiffs are seeking to enjoin Medicaid reductions based on § 1396a(a)(30)(A), including at least 25

[6] *See* Thomas H. Stanton, *The Administration of Medicare: A Neglected Issue*, 60 Wash. & Lee L. Rev. 1373, 1386 (2003).

cases in California.[7] Many of these cases have been stayed in anticipation of what this Court will do.[8] Courts around the country are poised to act on what this Court will hold.

4. The nuances identified by the Solicitor General, U.S. Br. 10, do not support denying review but, at most, suggest that *California Pharmacists* and *Santa Rosa* may be better vehicles.

The Solicitor General points to the Ninth Circuit's "alternative" holding in the present case that the reductions at issue were based on budgetary concerns. This alternative holding, however, is merely another example of a judicially imposed requirement that is encompassed within the second question

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[7] *See Cal. Pharmacists* Pet. App. 228-36 (listing cases); *see also CAHF v. Maxwell-Jolly*, CV 10-03259 (C.D. Cal.); *CAHSAH v. DHCS*, No. 04CS00543 (Ca. Super. Ct. (Sacramento)); *Cedars-Sinai Health Sys. v. DHCS*, No. BS124011 (Cal. Super. Ct. (Los Angeles)); *Developmental Servs. Network v. Maxwell-Jolly*, No. CV10-03284 (C.D. Cal.); *Hospital of Barstow, Inc. v. DHCS*, No. 34-2010-80000522 (Cal. Super. Ct. (Sacramento)); *Shield v. Maxwell-Jolly*, No. 34-2009-80000370 (Cal. Super. Ct. (Sacramento)); *Sierra Med. Servs. Alliance v. Maxwell-Jolly*, No. CV 10-4182 (C.D. Cal.); *Sierra Med. Servs. Alliance v. DHCS*, No. BS114671 (Cal. Super. Ct. (Los Angeles)).

[8] *See Cal. Pharmacists* Pet. App. 228-36; *see also Cal. Hosp. Ass'n v. Maxwell-Jolly*, No. 2:09-cv-3694-CAS-MAN (C.D. Cal.) (stay granted Sept. 7, 2010); *CAHF v. Maxwell-Jolly*, No. 2:10-cv-03259-CAS-MAN (C.D. Cal.) (stay granted June 24, 2010); *Santa Rosa Mem'l Hosp. v. Maxwell-Jolly*, No. 08-5173 SC (N.D. Cal.) (stay granted Aug. 30, 2010); *Indep. Living Ctr. of S. Cal. v. Shewry*, No. CV 08-3315 CAS (MANx) (C.D. Cal.) (stay granted June 15, 2010).

presented. Be that as it may, such concerns factor minimally if at all in the Ninth Circuit decisions comprising *California Pharmacists*.

The Solicitor General also cites the Ninth Circuit's speculation in this case (but not in *California Pharmacists* or *Santa Rosa*) that the rates "might" conflict with a "substantive" standard because they "apparently forced at least some providers to stop treating Medi-Cal beneficiaries." But § 1396a(a)(30)(A) does not require a state to maintain provider participation at historic levels. *See Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 537-38 & n.9 (3d Cir. 2002) (Alito, J.). What may be relevant is evidence that insufficient providers remain to serve the needs of beneficiaries – evidence that the Ninth Circuit neither cited nor addressed, because it did not exist.

Finally, the Solicitor General cites the Ninth Circuit's suggestion that the State failed to study the effect of the rate reduction in the present case in a "meaningful" way. "Meaningful" is not a standard that appears in § 1396a(a)(30)(A). In any event, the petitions (and appendix materials) in this case, *California Pharmacists*, and *Santa Rosa* describe the hundreds of pages of analysis and data supporting the reductions. The Ninth Circuit's quarrel with this massive evidentiary showing (particularly in the decisions combined in *California Pharmacists*) was not so much that it was "meaningless" as that it came too late, was not reviewed by the correct people, or was inadequately documented, according to rules that the Ninth Circuit announced with each new decision.

5. That the United States recently chose to deny several California SPAs is irrelevant to this issue too. The administrative process remains pending, and no doubt some if not all SPAs will be approved once the merits of California's position are actually considered. Meanwhile, but for the Ninth Circuit's erroneous construction of § 1396a(a)(30)(A), most, if not all, of the reductions at issue in *California Pharmacists* and *Santa Rosa* would be in effect *now*.

CONCLUSION

For the foregoing reasons and those stated in the petition and reply in support of the petition, the petition for writ of certiorari should be granted.

Dated: December 14, 2010

Respectfully submitted,

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AUG 09 2010

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Re: SPA 08-009B2 – Payment Reductions for "Prescription Drugs" Informal Response to CMS's RAI dated December 12, 2008

Dear Mr. Reed:

The enclosed document constitutes the Department of Health Care Services' (DHCS') informal response to the Centers for Medicare and Medicaid Services (CMS) Request for Additional Information (RAI) for SPA 08-009B2, dated December 12 2008. This SPA was originally submitted on September 30, 2008, as part of SPA-08-009.

Thank you in advance for your review and comments on this informal response to the RAI. Please note that this response should not be considered a formal response pursuant to Section 1915(f) of the Social Security Act.

On November 18, 2008, CMS staff informally requested four items of information by email. in late November 2008, DHCS informally responded to all but one of the four items. The one CMS question that DHCS did not respond to at that time asked for an explanation of the Federal budget impact in light of the 10% and 5% reductions for prescription drugs. On December 12, 2008, CMS sent a formal request for additional information in which it again asked for an explanation of the Federal budget impact in light of the reductions. Specifically, CMS asked DHCS to:

> "Please explain the Federal budget impact you provided on the CMS-179 form in light of the two rate reductions proposed in this SPA. The impact for Federal fiscal year (FFY) 2008 reflects three months of savings, yet the rate reduction for FFY 2009, which reflects 12 months, is greater than four times the impact for FFY 2008. These figures are confusing in light of the fact that the rate reduction percentage is cut in half five months into FFY 2009."

Subsequent to CMS's December 12, 2008 letter, the SPA was taken "off the clock."

CMS's request for an explanation of the Federal budget impact is the only outstanding formal request for additional information concerning this SPA. In an effort to get this SPA resolved, we appreciate your review of the enclosed informal and draft response.

Related Litigation

The payment reductions under this SPA are subject to court injunctions. Specifically, on August 18, 2008, the federal district court issued a preliminary injunction in the case of *Independent Living Center, et al. v. Maxwell-Jolly*, which prohibited DHCS from implementing the 10% payment reduction for prescription drugs for dates of service on or after August 18, 2008. In July 2009, the United States Court of Appeals for the Ninth Circuit issued a decision that affirmed the preliminary injunction and further mandated that it be amended to retroactively stop the 10% payment reduction for dates of service July 1, 2008 through August 17, 2008. In January 2010, the federal district court issued an amended preliminary injunction that bars DHCS from applying the 10% reduction to payments for prescription drugs for the entire period it was to be in effect (July 1, 2008-February 28, 2009). DHCS is currently in the process of paying pharmacies additional money owed for the period July 1, 2008 through August 17, 2008 in accordance with the amended preliminary injunction.

On February 26, 2009, the federal district court issued a preliminary injunction in the case of *Managed Care Pharmacy, et al. v. Maxwell-Jolly*, which prohibited DHCS from implementing the 5% payment reduction for prescription drugs that was to take effect on March 1, 2009. In March 2010, the Ninth Circuit Court of Appeals affirmed that preliminary injunction. Thus, DHCS has yet to actually implement the 5% payment reduction provided for by this SPA.

None of the courts have held that 10% or 5% reduced payment for prescription drugs would be inadequate or substantively violate federal Medicaid law, including the access requirement. Rather, the rationale that the courts have given for the injunctions has been that because the reductions were enacted by the State Legislature, the State Legislature could not validly enact them unless it first conducted or considered a pre-enactment study or evaluation to determine whether their reduced payments would comply with title 42 United States Code section 1396a(a)(30)(A). It is DHCS' position that these court decisions are in error and not supported by federal Medicaid law.

DHCS has filed petitions for certiorari with the United States Supreme Court concerning the Ninth Circuit decisions that affirmed the preliminary injunctions against the 10% and 5% payment reductions for prescription drugs. On May 24, 2010, the United States Supreme Court issued an order inviting the Solicitor General to file an amicus brief expressing the views of the United States government concerning the issues involved in this litigation. DHCS is hopeful that the Supreme Court will grant certiorari and that the court injunctions that have blocked implementation of the payment reductions for prescription drugs will be overturned.

Proposal Regarding Court Orders

In light of the court orders that have been issued, we would like to propose some additional language in the

SPA that takes court orders into account. Specifically, we would propose that a paragraph B.4 be added to Supplement 2 to Attachment 4.19-B of the State Plan, which states the following.

> "The payment reductions in paragraphs B.2 and B.3 will not be implemented to the extent that they are subject to a court order, or orders, that prohibit implementation."

While DHCS is hopeful that the preliminary injunctions concerning the payment reductions for prescription drugs will eventually be overturned, this proposed language would insure that DHCS will not be in violation of the State Plan if there remains any court order blocking implementation. Such language would also hopefully resolve any CMS concerns about approving the SPA in light of any outstanding court orders. Please advise if you are agreeable to this addition.

Please Advise if You Need Additional Information

In July 2009, Michelle Baldi of CMS informally requested analyses and other documents that supported DHCS' determination that the reduced payments for prescription drugs would comply with federal Medicaid requirements, including the access requirement. DHCS sent these documents to Ms. Baldi in late July 2009. If you have any questions about these documents, or if you have any other questions concerning this SPA, please let us know.

We look forward to receiving your comments. After receiving your comments, we would like to then prepare and submit a formal response to your RAI.

If you have any further questions, please contact Ms. Pilar Williams, Chief, Pharmacy Benefits Division, at (916) 552-9608. If you have questions concerning the litigation, please contact Mr. Timothy Cornforth, Senior Staff Counsel, at (916) 440-7842.

Sincerely,

/s/ Toby Douglas
Toby Douglas
Chief Deputy Director
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Enclosure

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Informal Response to the
Request for Additional Information
SPA 08-009B2

Request for Additional Information,
December 12, 2008

Question

Please explain the Federal budget impact you provided on the CMS-179 form in light of the two rate reductions proposed in this SPA. The impact for Federal fiscal year (FFY) 2008 reflects three months of savings, yet the rate reduction for FFY 2009, which reflects 12 months, is greater than four times the impact for FFY 2008. These figures are confusing in light of the fact that the rate reduction percentage is cut in half five months into FFY 2009.

Answer

DHCS has re-evaluated what the fiscal impact would have been for FFY 2008 and FFY 2009 if the preliminary injunctions against the 10% and 5% payment reductions for prescription drugs had not been issued. If the preliminary injunctions had not been issued, DHCS estimates that the total savings in federal and state dollars in FFY 2008 would have been $77,076,000 and that the total savings in federal and state dollars in FFY 2009 would have been $209,580,000. These estimates are based on the impact of a 10% payment reduction for dates of service July 1, 2008 through February 28, 2009, and a 5% payment reduction for dates of service March 1, 2009

through September 30, 2009. DHCS estimates that the federal budget impact would have been $38,538,000 for FFY 2008 and $134,623,000 for FFY 2009. These estimates assumed 50% federal financial participation (FFP) for FFY 2008 and 61.59% FFP for FFY 2009.

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Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

SPA 08-009A – NON-CONTRACT INPATIENT HOSPITAL SERVICES

Dear Mr. Cooley:

The enclosed document and the enclosed State Plan Amendment (SPA) constitute the Department of Health Care Services' (DHCS') informal response to the Centers for Medicare & Medicaid Services (CMS) Request for Additional Information (RAI) for SPA 08-009A. This SPA was originally submitted on September 30, 2008, as part of SPA 08-009. At DHCS' request, in a letter dated December 9, 2008, the SPA was taken "off the clock" by CMS for purposes of responding to the RAI.

Thank you in advance for your review and comments on the informal response to the RAI. Please note that this informal response should not be considered a formal response pursuant to Section 1915(f) of the Social Security Act, and the SPA will remain "off the clock". As you know, portions of the subject matter of this SPA are currently subject to a court injunction and are on hold until that matter is resolved.

To address the topic of the injunctions and other court orders, DHCS is suggesting that the following language be inserted as a new subparagraph (4) in paragraph (M) at page 3.2 of Attachment 4.19-A, to read:

> "(4) The payment limitation in paragraph (1) will not be implemented to the extent that it is subject to an injunction or other court order (or orders) that prohibit or restrict implementation."

This language would insure that, if the SPA is ultimately approved, DHCS will have language that indicates that it is not in violation of the State Plan if there is a court order blocking a payment reduction. Another benefit might be that such language would address any CMS concerns about approving the SPAs in light of outstanding court orders.

If you have any further questions regarding these documents, please contact Mr. Bob Sands, Chief, Safety Net Financing Division, at (916) 552-9154.

Sincerely,

/s/ Toby Douglas
Toby Douglas
Chief Deputy Director
Health Care Programs

Enclosure

cc: Gloria Nagle
Associate Regional Administrator
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Informal Response to the Request for Additional Information
SPA 08-009A
September 3, 2010

GENERAL

Question 1: **Please provide a redlined version of the State plan pages so that we can be certain that we have identified all intended changes.**

Response: The redlined version of the SPA is submitted as an attachment to these responses. Since SPA 08-009A was submitted initially, the State enacted the Health Budget Bill for SFY 2009-10 (Assembly Bill [AB] 5 enacted in the 2009-10 Fourth Extraordinary Session [ABx4 5]) which reapplied a ten percent payment reduction for specified small and rural hospitals, effective July 1, 2009. (See California Welfare and Institutions (W&I) Code section 14166.245, subdivision (g).) This change is included in the redlined version of the SPA at page 3.2.

Question 2: **Do we have your permission to make a pen-and-ink change to add in the Federal citation "42 CFR 447 Subpart C" to Box 6 of the HCFA-179?**

Response: Yes.

Question 3: **Please provide support/explanation as to how the State computed the fiscal impact for Box 7 of the HCFA-179:**

FFY 07-08 (3 months):	**$ 42.5 million**
FFY 08-09:	**$ 60.6 million**

These numbers should accurately reflect the reimbursement changes implemented by this SPA, which includes a 3-month 10% cut for the last quarter of FFY 07-08 and a 10% cut for the entire FFY 08-09.

Response: In state legislation applicable to state fiscal year 2008-09 (ABx3 5, adding W&I Code section 14166.245), payments for inpatient services rendered in non-contract hospitals were reduced by ten percent, effective for dates of service beginning July 1, 2008.

State law was amended in September 2008 related to payments to non-contract hospitals. (See AB 1183 [2008] amending W&I Code section 14166.245.) Those amendments provided that, effective October 1, 2008, non-contract hospitals were subject to a further rate limitation based on the average regional contract rate minus five percent. (See SPA #08-019.) Reimbursement for inpatient services in non-contract hospitals were divided into three categories: (a) those non-contract hospitals, which are in a closed Health Facility Planning Area (HFPA) or in an open HFPA with three or more non-state hospitals with acute care beds, (b) non-contract hospitals in an open HFPA with less than three acute non-state hospitals with acute care beds, and (c) small and rural hospitals. The non-contract hospitals that are subject to the additional reduction are those that are in a closed HFPA, or in an open HFPA with three or more non-state owned hospitals with acute care beds.

AB 1183 also established a specific time period during which payments for inpatient services for small and rural hospitals are to be reduced by ten percent; that period is for dates of service from July 1, 2008, through and including October 31, 2008. Further, AB 1183 provided that non-contract, small and rural hospitals were not subject to any payment reductions beginning November 1, 2008, through and including June 30, 2009.

Effective July 1, 2009, state law was further amended to apply a ten percent payment reduction to those non-contract, small and rural hospitals that were neither federal Rural Referral Centers nor Critical Access Hospitals. (See ABx4 5 [2009] amending W&I Code section 14166.245.) Thus, only the non-contract, small and rural hospitals to which the exception does not apply are currently subject to the ten percent payment reduction.

The fiscal impact represented in Box 7 of HCFA-179 was calculated to reflect the federal fund savings that will result from the rate reductions set forth in SPA 08-009A. The amounts above should be revised to $7 million for the FFY 07-08, and to $22 million for FFY 08-09. The total annual expenditures for non-contract hospitals are estimated to be $716 million. A payment lag will result in estimated annual savings of $44 million in total funds. The federal funds saved as a result of the reductions will be an estimated $22 million per year, or approximately $7 million per quarter. These numbers accurately reflect the re-imbursement changes set forth in the SPA, which

include a 3-month 10 percent cut for the last quarter of FFY 07-08 and a 10 percent cut for all of FFY 08-09.

Question 4: **Please confirm that the reduction injunction imposed as of 8/18/2008, as discussed in the State's SPA transmittal letter, is not applicable to 4.19A reimbursement. Please also discuss any other pending lawsuit impacting the 4.19A payment reduction, including the most current status.**

Response: On August 18, 2008, and again on September 15, 2008, the United States District Court for the Central District of California determined, in the case of *Independent Living Center of Southern California et al.* v. *Shewry* (Case No CV08-03315), that inpatient services provided by non-contract hospitals are *not* subject to a preliminary injunction, issued by that court, which enjoined the ten percent payment reduction for various other services. This means that the ten percent reduction remains in effect (with the exception discussed below as a result of the *Santa Rosa Memorial Hospital* lawsuit).

As referred to above, the United States District Court for the Northern District of California issued a preliminary injunction, in the case of *Santa Rosa Memorial Hospital, et al*. v. *David Maxwell-Jolly* (Case No. 08-5173 SC), on November 18, 2009, which was clarified on December 10, 2009. Effective for dates of service on or after November 18, 2009, the Department of Health Care Services (DHCS) is preliminarily

enjoined from implementing the ten percent payment reduction for the seventeen providers who were the named plaintiffs in the lawsuit. DHCS appealed to the Ninth Circuit Court of Appeals. On May 27, 2010, the Ninth Circuit, in a Memorandum opinion, affirmed the preliminary injunction, as issued on November 18, 2009, with respect to the ten percent payment reduction (citing its earlier rulings in *Independent Living* and *California Pharmacists Association et al*. v. *David Maxwell-Jolly* [Case No. CV09-00722CAS]).

Neither the district court nor the Ninth Circuit held that 10 percent reduced payments for non-contract hospitals were insufficient or that the reduced payments substantively violated any federal Medicaid law. Rather, the basis for the preliminary injunction was the federal court's conclusion that Title 42, United States Code, section 1396a(a)(30)(A) required the State Legislature itself to conduct or consider a study regarding the "efficiency, economy, and quality of care" and access provisions of federal Medicaid law prior to enacting Assembly Bill ABx3 5. DHCS believes that this conclusion is erroneous and filed petitions for certiorari with the United States Supreme Court in March 2010 concerning similar Ninth Circuit decisions in *Independent Living* and *California Pharmacists Association*. On May 23, 2010, the Supreme Court issued an order inviting the Solicitor General to file an amicus brief on behalf of the United States in *Independent Living*. On August 25, 2010, DHCS also filed a petition for certiorari with the

Supreme Court concerning the Ninth Circuit's decision in the *Santa Rosa* case.

In addition, a lawsuit, entitled *California Hospital Association* v. *David Maxwell-Jolly* (Case No. CV 09-08642 CAS), was filed in the United States District Court on November 24, 2009, to enjoin the State from implementing the ten percent payment reduction in state law for certain small and rural hospitals that became effective July 1, 2009, as enacted in ABx4 5 (2009). A preliminary injunction was issued by the District Court against the State requiring it to refrain from enforcing this state law beginning February 24, 2010. Similar to previous preliminary injunctions, the court did not find that the 10 percent reduced payments were inadequate or that they substantively violated federal Medicaid law. Rather, the basis upon which the court granted a preliminary injunction was again its conclusion that 42 United States code section 1396a(a)(30)(A) required the State Legislature itself to conduct or consider a study regarding the "efficiency, economy, and quality of care" and access prior to its enactment of ABx 4 5 (2009). As noted above, DHCS believes this conclusion to be erroneous, and has appealed the preliminary injunction. Currently, appellate proceedings are stayed by order of the Ninth Circuit, pending a decision by the Supreme Court on DHCS' petition for certiorari in *Independent Living* and *California Pharmacists Association*.

Question 5: **Please confirm that only non-contract hospital reimbursement, as provided for in the methodology described on page 2 to page 17.37 of Attachment 4.19A, is subject to the reduction and that all other hospital reimbursements provided for in Attachment 4.19A are not affected.**

Response: Only non-contract hospitals that are subject to the reimbursement methodology described in Attachment 4.19-A, pages 2 to 17.37, are subject to the inpatient hospital payment reduction.

Question 6(a): **Please confirm that the State has complied with the assurance requirement regarding access to care per 42 CFR 477.253(b)(1)(ii)(C) for inpatient rates.**

Response: The federal government enacted 42 CFR 447.253(b)(1)(ii)(C) to implement the now repealed Boren Amendment, which was formerly codified at 42 United States Code section 1396a(a)(13). The language in this federal regulation duplicates language that was contained in the Boren Amendment. Congress repealed the Boren Amendment effective October 1, 1997. The United States Department of Health and Human Services (USDHHS) informed the states that for dates of service on or after October 1, 1997, they no longer had to comply with the findings and assurances requirements of the Boren Amendment. USDHHS wrote to DHCS on January 28, 1999, confirming that because of the repeal of the Boren Amendment, states no longer are required to comply

with the findings and assurances requirements of 42 CFR, §§ 447.253 and 447.255.

Question 6(b): **What impact, if any, does the proposed SPA have on access to inpatient hospital care in California?**

Response: DHCS has determined that the 10 percent reduction for non-contract hospital inpatient services has had no negative impact on Medi-Cal recipients access to hospital inpatient services.

With respect to hospitals that do not contract with the state of California (non-contract hospitals), health facility planning areas (HFPAs) have been designed to ensure reasonable access to care by taking into account geographic location and reasonable travel time for inpatient hospital services. (See Title 22, California Code of Regulations, section 90811.)

DHCS has performed a needs capacity analysis, based on the California Office Of Statewide Health Planning and Development data reflecting licensed bed capacity, patient days, and Medi-Cal utilization to arrive at the bed vacancy for each hospital. It was then determined to what degree the hospital vacancy, as a percentage, is available in relationship to the Medi-Cal patient utilization. Based on this analysis, DHCS has determined that the capacity of each HFPA exceeds the current Medi-Cal patient caseload. In addition, 48 percent of licensed bed days in each of the HFPAs affected by the SPA are unused; these unused bed days will serve any increase in

the Medi-Cal caseload and will not lead to an increase in caseload.

Contract hospitals provide approximately 88 percent of all hospital inpatient days rendered to Medi-Cal recipients and are required by contract to provide services to all Medi-Cal recipients that need hospital inpatient services. The payment reductions do not apply to contract hospitals. DHCS evaluated paid claims data, for the period July 1, 2008 through October 31, 2008 when all non-contract hospitals, including small and rural hospitals, were subject to at least a 10 percent reduction, as provided for under SPA 08-009A. This data demonstrates that the 10 percent reduction had no negative impact on non-contract hospital participation in the program. Thus, DHCS has concluded that the payment reductions for non-contract hospitals under SPA 09-008A has not negatively impacted access to hospital inpatient services for Medi-Cal recipients.

STATE PLAN PAGES

Question 7: **In 4.19A, page 3.2, paragraph M(1) states that the reimbursement limit per paragraph II.A is 90% of allowable cost as determined in that paragraph. How about the other limits as discussed in paragraph II.A? Per paragraph II.A., hospital reimbursement is computed to be the lowest of four variables, one of which is allowable cost (paragraph II.A.2). The other three variables are customary charges;**

all-inclusive rate per discharge limitation (ARPDL); and peer grouping rate per discharge limitation (PGRPDL). Do these three variables need to be reduced accordingly? For example, if the PGRPDL is lower than 90% of a hospital's cost (and also lower than customary charges and the ARPDL), would the hospital then be reimbursed at the full amount of the PGRPDL? Or is it the State's intention that the hospital will only be reimbursed at 90% of whatever it would have gotten based on the lowest-of comparison (which means the reduction factor should apply to also paragraphs II.A.1, 3, and 4)?

Response: The newly added paragraph M(1), at page 3.2 of Attachment 4.19-A, states that the reimbursement limit set forth in paragraph II.A (at page 2) will be 90 percent of the allowable cost limitation described in that paragraph. In other words, the 10 percent reduction does not apply to the ARPDL, PGRPDL, or the customary charge limitation. Thus, if the PGRPDL is lower than 90 percent of a hospital's audited allowable costs, the hospital would be reimbursed at the full amount of the PGRPDL.

The following funding questions are being asked and should be answered in relation to all payments make to all providers under Attachment 4.19A of your State plan.

Question 8: **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

Response: Except as noted below, hospitals do not return any portion of payments (Federal or State share) to the State, any local governmental entity, or any other intermediary organization.

Medi-Cal payments for inpatient services, including supplemental or enhanced reimbursements, are paid by the State directly to the hospital that has provided services. After the payments are made, only hospitals that are reimbursed using CPEs must return any portion that exceeds the allowable costs if it is determined at the final settlement that there is an excess.

The excess is returned to the Health Care Deposit fund and the Federal funds are returned to the Federal government.

Likewise, non-contract hospitals only return the portion that exceeds the allowable costs, if it is determined at the final settlement of their cost report that there is an excess. The excess is returned to the Health Care Deposit fund and the Federal funds are returned to the Federal government.

Question 9(a): **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.**

Response: The source of the State's share of payments depends on the type of hospital that has provided the services.

Under the State's current Section 1115 Demonstration project, hospital providers are classified into three categories: designated public hospitals (DPHs), nondesignated public hospitals (NDPHs), and private hospitals (Privates). For NDPHs and Privates, the State share comes from legislative appropriations, as state general funds used for Medi-Cal payments which are paid on a per diem basis. For DPHs, the State uses CPEs that represent the hospital's total costs (total computable) to claim Federal funds.

In addition, the State's share of Medi-Cal payments of supplemental reimbursements to DPHs may be from the CPEs reported to the State, or through intergovernmental transfers that are used to fund the non-Federal share of payments. Some Privates receive payments where the non-federal share is funded by intergovernmental transfers provided by non-state governmental entities. The non-federal share of all other supplemental payments made by the State is derived from State general funds. (Please see attached table delineating funding sources for various payments.)

Question 9(b): **Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment.**

Response: Total expenditures and State share amounts for each type of Medicaid payment made in State Fiscal Year 2006-07 (July 1, 2006-June 30, 2007):

Medi-Cal

Payment Type	Total Expenditure	State share
Normal per diem	$ 4,055 million	$ 2,028 million
Supplemental	$ 2,452 million	$ 1,633 million
Enhanced	$ 0	$ 0
Other	$ 0	$ 0

Question 9 (c): **If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds.**

Response: As specified in the State's current Demonstration project, CPEs are used for the claiming of FFP in the supplemental reimbursement programs. Submission of CPL and resulting claims for FFP require documentation based on the provider's accounting records. The provider submits worksheets and other documents with its claim. DHCS reviews the claim for accuracy and completeness to ensure that the underlying documentation is sufficient to support the claim of Federal funds.

In the case of IGT-supported payments, after IGTs are received by the State from each public agency, a total-funds (total computable) payment is made to the public provider. That payment is then used as the basis for a claim of Federal funds. It takes less than one month from the point in time at which the public agency receives notice that the IGT will be needed until the payment is made to the associated provider.

Question 9 (d): **If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).**

Response: CPEs are based on data reported in the Hospital Cost Report (CMS 2552-96). An accompanying workbook is used to determine the allowable costs to be claimed by the provider. The as-filed report is used to initially draw federal funds periodically during the fiscal year When the Hospital Cost Report is audited, the final distribution is adjusted based on the final audited amount.

Question 9 (e): **For any payment funded by CPEs or IGTs, please provide the following:**

a complete list of the names of entities transferring or certifying funds; the operational nature of the entity (state, county, city, other);

the total amounts transferred or certified by each entity;

clarify whether the certifying or transferring entity has general taxing authority; and,

whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response:

Payments Funded by IGTs For State Fiscal Year 2007-08 (July 1,2007-June 30, 2008)

Facility Name	Operational Nature	FFP (IGT based)	Taxing Authority	Received State Appropriations
ALAMEDA COUNTY MEDICAL CENTER – HIGHLAND CAMPUS	County	$ 34,551,113	County has taxing authority	No
ARROWHEAD REGIONAL MEDICAL CENTER	County	$ 23,128,877	County has taxing authority	No
CONTRA COSTA REGIONAL MEDICAL CENTER	County	$ 14,146,497	County has taxing authority	No
KERN MEDICAL CENTER	County	$ 12,702,916	County has taxing authority	No
LAC, HARBOR UCLA MEDICAL CENTER	County	$ 39,300,948	County has taxing authority	No
LAC, MLK/DREW MEDICAL CENTER	County	$ 5,851,331	County has taxing authority	No
LAC, OLIVE VIEW – UCLA MEDICAL CENTER	County	$ 34,923,741	County has taxing authority	No
LAC RANCHO LOS AMIGOS NRC	County	$ 8,593,329	County has taxing authority	No
LAC, USC MEDICAL CENTER	County	$ 94,152,567	County has taxing authority	No
NATIVIDAD MEDICAL CENTER	County	$ 5,571,406	County has taxing authority	No
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	County	$ 25,736,803	County has taxing authority	No
SAN FRANCISCO GENERAL HOSPITAL	County	$ 24,186,920	County has taxing authority	No
SAN JOAQUIN GENERAL HOSPITAL	County	$ 8,904,762	County has taxing authority	No
SAN MATEO MEDICAL CENTER	County	$ 7,707,765	County has taxing authority	No
SANTA CLARA VALLEY MEDICAL CENTER	County	$ 35,179,373	County has taxing authority	No
UC DAVIS MEDICAL CENTER	State	$ 19,052,744	State has taxing authority	No
UC IRVINE MEDICAL CENTER	State	$ 17,881,101	State has taxing authority	No
UC SAN DIEGO MEDICAL CENTER	State	$ 14,409,508	State has taxing authority	No
VENTURA COUNTY MEDICAL CENTER	County	$ 7,999,089	County has taxing authority	No

Payments Funded by CPEs For State Fiscal Year 2007-08 (July 1, 2007-June 30, 2008)

Facility Name	Operational Nature	FFP (CPE based)	Taxing Authority	Received State Appropriations
ALAMEDA COUNTY MEDICAL CENTER – HIGHLAND CAMPUS	County	$ 14,727,273	County has taxing authority	No
ARROWHEAD REGIONAL MEDICAL CENTER	County	$ 35,716,261	County has taxing authority	No
CONTRA COSTA REGIONAL MEDICAL CENTER	County	$ 3,705,790	County has taxing authority	No
KERN MEDICAL CENTER	County	$ 31,746,004	County has taxing authority	No
LAC, HARBOR UCLA MEDICAL CENTER	County	$ 38,759,514	County has taxing authority	No
LAC, MLK/DREW MEDICAL CENTER	County	$ 5,314,614	County has taxing authority	No
LAC, OLIVE VIEW – UCLA MEDICAL CENTER	County	$ 20,717,514	County has taxing authority	No
LAC RANCHO LOS AMIGOS NRC	County	$ 21,665,078	County has taxing authority	No
LAC, USC MEDICAL CENTER	County	$ 77,059,175	County has taxing authority	No
NATIVIDAD MEDICAL CENTER	County	$ 9,523,563	County has taxing authority	No
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	County	$ 29,035,763	County has taxing authority	No
SAN FRANCISCO GENERAL HOSPITAL	County	$ 33,727,995	County has taxing authority	No
SAN JOAQUIN GENERAL HOSPITAL	County	$ 14,247,821	County has taxing authority	No
SAN MATEO MEDICAL CENTER	County	$ 3,966,511	County has taxing authority	No
SANTA CLARA VALLEY MEDICAL CENTER	County	$ 44,993,244	County has taxing authority	No
UC DAVIS MEDICAL CENTER	State	$ 7,182,486	State has taxing authority	No
UC IRVINE MEDICAL CENTER	State	$ 28,644,318	State has taxing authority	No
UC SAN DIEGO MEDICAL CENTER	State	$ 36,070,850	State has taxing authority	No
UC SAN FRANCISCO MEDICAL CENTER	State	$ 21,671,523	State has taxing authority	No
UCLA MEDICAL CENTER	State	$ 13,537,818	State has taxing authority	No
VENTURA COUNTY MEDICAL CENTER	County	$ 12,754,680	County has taxing authority	No

Question 10: **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type**.

Response: Total amounts of supplemental or enhanced payments made to each provider type for State Fiscal Year 2006-07 (July 1, 2006-June 30, 2007):

State owned	$ 256,348,560
Non-State Gov't-owned	$ 1,142,686,203
Private	$ 233,918,130

Question 11: **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.**

Response: At the outset, it should be noted that SPA 08-009A applies primarily to privately owned, non-contract hospitals. As of March 1, 2010, of the approximately 200 non-contract hospitals, ninety-nine privately-owned and operated, non-contract hospitals

are subject to the reduction implemented in this SPA. In addition, approximately 200 privately-owned and operated hospitals (private hospitals) are contract hospitals and are not subject to this SPA. The State's compliance with the UPL for private hospitals is determined as explained below.

Private hospitals are paid either a Selective Provider Contracting Program (SPCP) contract rate; or, if they are non-contract hospitals, costs (or costs reduced by an adjustment for the Peer-grouping Inpatient Reimbursement Limitation [PIRL]).

Regardless of which payment methodology noted above is applicable, private hospitals as a group would never be paid more than their costs. While a few private hospitals, e.g., some children's hospitals, may be paid above their costs under the SPCP contract rate, the vast majority of private hospitals are paid, in the aggregate, significantly below costs. This means that the entire UPL category of hospitals is well below costs. UPL compliance is demonstrated because it is well established that costs in the aggregate are equal to, or less than, payments that would result if Medicare Payment Principles were applied. Supplemental payments are, in some instances, authorized by the State's Medi-Cal Hospital/ Uninsured Care Section 1115 Demonstration (Demonstration project), but are subject to the limitations and conditions imposed under the Demonstration project.

Historically, CMS has on various occasions agreed that the privately-owned group of hospitals do not exceed the applicable UPL, as described below:

In 2000, at the time of the initial publication of the new Federal UPL regulations, the State was in the process of requesting the renewal of its SPCP waiver. In the December 11, 2001, submission of the response to the RAI for this waiver, there was a question regarding the UPLs. The State submitted the above explanation regarding the UPL for the private hospital category and CMS accepted it for purposes of the renewal of the SPCP waiver.

When the Demonstration project was being negotiated (in 2004 and 2005), the State submitted information regarding Compliance with the privately owned hospital's UPL, CMS accepted this showing.

In addition, a number of studies and models from independent sources have determined that Medicaid payments to hospitals in California provide a percentage of costs that is lower than is paid by Medicare. One specific independent study, "Cost Shifting in California Hospitals: What Is the Effect on Private Payers?", by Daniel P. Kessler, dated June 6, 2007, used the California Office Of Statewide Healthcare Planning and Development data of acute care hospitals to determine revenue-to-cost- ratios to compare among payer types. The study concluded that, in the aggregate, Medicaid payments were less than Medicare payments.

Although the California Medical Assistance Commission does not maintain its rate information by the UPL categories, the average percentages of rate changes of 6.1 percent, and the percentage of rate change by hospital bed size of 4.73 percent for 1-99 beds, 6.85 percent for 100-299 beds and 6.14 percent for 300 plus beds, were less than or very close to the CPI increase for hospital services of 6.8 percent, from 2007 to 2008, the most recent data available. Because the CPI is used in calculating future years' UPLs, it can reasonably be concluded that the private hospitals would be paid less than the UPL.

California does not believe that it is necessary to separately calculate a UPL using Medicare Payment Principles for the other two categories of hospitals (State owned and Non-state Government-owned) for the following reasons:

State owned hospitals that provide mental health services and acute care services for veterans are paid an interim rate per day, which is reconciled with actual costs through audit. Any federal funds paid in the interim rate above cost, as determined by audit, are returned to the federal government. These State hospitals are not SPCP contract hospitals and do not receive any supplemental payments. The other hospitals in this category are the University of California hospitals. These hospitals are paid through the Demonstration project as part of the "designated public hospitals" and the UPL for this group is defined in and calculated through the Demonstration project.

Non-state government owned hospitals may be paid in one of three ways: (1) their actual reimbursable costs based on their audited cost report; (2) a negotiated SPCP contract rate; or (3) as a "designated public hospital" under the Demonstration project. All government-owned hospitals are governed to some extent by the requirements of the Special Terms and Conditions of the Demonstration project. It is the State's conclusion that the UPL for the class is not exceeded.

Question 12 (a): **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services?**

Response: To the best of the State's knowledge, no governmental provider receives payments that in the aggregate are greater than the reasonable costs of providing services, to the extent that such a limitation is applicable. With respect to various supplemental payments (e.g., the Disproportionate Share Hospital program), payments are limited by the specific restrictions that are applicable to the amounts of those payments.

Question 12 (b): **If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

Response: If a payment exceeds applicable payment limitations (including the cost of services where

applicable), the Federal share of the excess is recouped and returned to CMS through the quarterly expenditure reporting system (CMS-64). For example, if DHCS determines that a hospital has been paid more than the applicable reimbursement limit for that hospital (e.g. 90% of allowable costs or ARPDL), DHCS takes action to recoup the excess and return the associated FFP to CMS on the quarterly expenditure report.