An asterisk before and after content indicate redlined or crossed out language that will be taken out of the attachment

"This Appendix 2 to Attachment 4.19-A comprises the "prior DSH methodology" in effect as of the 2004-05 payment adjustment year. The calculations set forth in this Appendix 2, including the strikeouts and interlineations in the document, are applicable solely for purposes of determining the payment adjustments for non cost-based DSH facilities and determining the proportionate share of payment adjustments for non-government operated hospitals pursuant to subsection D.1 and subsection A.3, respectively, of the DSH segment of Attachment 4.19-A (TN 05-022)."

INCREASE IN MEDICAID PAYMENT AMOUNTS FOR
CALIFORNIA DISPROPORTIONATE PROVIDERS

A. Disproportionate Share Hospitals

1. All hospitals in the State reimbursed under the State Plan provisions or the Selective Provider Contracting Program which meet the disproportionate share provider criteria specified in subsection 2 shall receive additional payment amounts (i.e., payment adjustments). The additional payment amounts shall be determined using the method described in Section C below, as modified by other provisions of this Attachment. * ~~The disproportionate share payment amounts shall be distributed concurrent with certain claims that are processed on and after July 1, 1991, as described in this attachment. For the 1994-95 and 1995-96 payment adjustment years, the payments shall be made for three quarters of the state fiscal year by adjusting the payment adjustment amounts in accordance with Sections H. and I. of this Attachment.~~* In addition, the Department shall pay to eligible hospitals any supplemental lump-sum payment adjustment amounts and any secondary supplemental payment adjustments that are payable and shall adjust payment amounts, in accordance with applicable provisions of this Attachment.

2. Hospitals shall be deemed disproportionate share hospitals if for a calendar year ending 18 months prior to the beginning of a particular State fiscal year:

   a. The hospital's Medicaid inpatient utilization rate as defined in Section 1396 r-4 (b)(2) of Title 42 of the United States Code, is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or

   b. The hospital's low income inpatient utilization rate as defined in Section 1396 r-4 (b)(3) of Title 42 of the United States Code, exceeds 25 percent;

   and in each case,

   c. The hospital has at least two obstetricians with staff privileges at the hospital who have agreed

to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the U.S. Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital (1) the inpatients of which are predominantly individuals under 18 years of age; or (2) which does not offer nonemergency obstetric procedures as of December 22, 1987; and

d. *~~For the 1994-95 payment adjustment year and subsequent payment adjustment years, the hospital's Medicaid inpatient utilization rate, as computed under paragraph a. above, is at least one percent~~*

B. **Definitions**

The following definitions apply for purposes of this Attachment:

1. "Department" means the State Department of Health Services.

2. "Disproportionate share list" means an annual list of disproportionate share hospitals that provide acute inpatient services issued by the Department for purposes of this Attachment.

3. "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.

4. "Eligible hospital" means a hospital included on a disproportionate share list, which is eligible to receive payment adjustments under this Attachment with respect to a particular state fiscal year.

5. "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

6. "Payment adjustment" or "payment adjustment amount" means an amount paid under this Attachment for acute inpatient hospital services provided by a disproportionate share hospital.

7. "Payment adjustment year" means the particular state fiscal year with respect to which payments are to be made to eligible hospitals under this Attachment.

8. "Payment adjustment program" means the system of Medi-Cal payment adjustments for acute inpatient hospital services established by this Attachment.

State: California

9. "Annualized Medi-Cal inpatient paid days" means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular payment adjustment year, including all Medi-Cal acute inpatient-covered days of care for hospitals which are paid on a different basis than per diem payments.

10. "Low-income utilization rate" means a percentage rate determined by the Department in accordance with the requirements of Section 1396r-4(b) (3) of Title 42 of the United States Code, and included on a disproportionate share list.

11. "Low-income number" means a hospital's low-income utilization rate rounded down to the nearest whole number, and included on a disproportionate share list.

12. "1991 Peer Grouping Report" means the final report issued by the Department dated May 1991, entitled "Hospital Peer Grouping."

13. "Major teaching hospital" means a hospital that meets the definition of a university teaching hospital, major nonuniversity teaching hospital, or large teaching emphasis hospital as set forth on page 51 of the 1991 Peer Grouping Report.

14. "Children's hospital" means a hospital that meets the definition of a children's hospital-state defined, as set forth on page 53 of the 1991 Peer Grouping Report, or which is listed in subdivision (a), or subdivision (c) to (g), inclusive, of Section 16996, of the California Welfare and Institutions Code.

15. "Acute psychiatric hospital" means a hospital that meets the definition of an acute psychiatric hospital, a combination psychiatric/alcohol-drug rehabilitation hospital, or a psychiatric health facility, to the extent the facility is licensed to provide acute inpatient hospital service, as set forth on page 52 of the 1991 Peer Grouping Report.

TN #92-17
supersedes
TN #91-15

Approval Date: MAY 10 1993 Effective Date: ~~July 1, 1992~~ NOV 14 1992 CW 5-20-93

16. "Alcohol-drug rehabilitation hospital" means a hospital that meets the definition of an alcohol-drug rehabilitation hospital as set forth on page 52 of the 1991 Peer Grouping Report.

17. "Emergency Services Hospital" means a hospital that is a licensed provider of basic emergency services as described in Sections 70411 to 70419, inclusive, of Title 22 of the California Code of Regulations, or that is a licensed provider of comprehensive emergency medical services as described in Sections 70451 to 70459 inclusive, of Title 22 of the California Code of Regulations.

18. "OSHPD" means the Office of Statewide Health Planning and Development.

19. "OSHPD" statewide data base file" means the OSHPD statewide data base file from all of the following:

    (A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 128735 (formerly Section 443.31) of the Health and Safety Code, for hospital fiscal years which ended during the calendar year ending 13 months prior to the applicable February 1.

    (B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 127285 (formerly Section 439.2) of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

    (C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to subdivision (g) of Section 128735 (formerly Section 443.31) of the Health and Safety Code for the calendar year ending 13 months prior to the applicable February 1.

20. "Acute inpatient hospital day", for the purposes of this Attachment, will include days in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward

and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

21. "Total per diem composite amount" means, for each eligible hospital for a particular payment adjustment year, the total of the various per diem payment adjustment amounts to be paid to the hospital for each eligible day as calculated under applicable provisions of this Attachment.

22. "Supplemental lump-sum payment adjustment" means a lump-sum amount paid under this Attachment for acute inpatient hospital services provided by a disproportionate share hospital, but does not include secondary supplemental payment adjustments as described in subsection 26.

23. "Projected total payment adjustment amount" means, for each eligible hospital for a particular payment adjustment year, the amount calculated by the Department as the projected maximum total amount the hospital is expected to receive under the payment adjustment program for the particular payment adjustment year (including all per diem payment adjustment amounts and any applicable supplemental lump-sum payment adjustments, but not including secondary supplemental payment adjustments as described in subsection 26).

24. "To align the program with the federal allotment" means to modify the size of the payment adjustment program to be as close as reasonably feasible to, but not to exceed, the estimated or actual maximum state disproportionate share hospital allotment for the particular federal fiscal year for California under Section 1396r-4(f) of Title 42 of the United States Code.

25. "Descending pro rata basis" means an allocation methodology under which a pool of funds is distributed to hospitals on a pro rata basis until one of the recipient hospitals reaches its maximum payment limit, after which all remaining amounts in the pool are distributed on a pro rata basis to the recipient hospitals that have not reached their maximum payment limits, until another hospital reaches its maximum payment limit, and which process is repeated until the entire pool of funds has been distributed among the recipient hospitals.

26. *~~"Secondary supplemental payment adjustment" means a payment adjustment amount, whether paid or payable, to an eligible hospital as a second type of supplemental distribution earned as of June 30, 1996, with respect to the 1995-96 payment adjustment year~~.*

27. "OBRA 1993 payment limitation" means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under the provisions of Section 1396r-4(g) of Title 42 of the United States Code, as implemented pursuant to Section J. below.

28. [Intentionally Left Blank]

29. "Public hospital" means a hospital that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

30. "Nonpublic hospital" means a hospital that satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; does not meet the definition of a nonpublic/converted hospital as described in subsection 31; and does not meet the definition of a converted hospital as described in subsection 32.

31. "Nonpublic/converted hospital" means a hospital that satisfies all of the following, or, if two or more inpatient facilities are licensed by the Department under a consolidated license, a hospital as to which any component of the hospital satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; at any time during the 1994-95 payment adjustment year, was a public hospital as described in subsection 29 (whether or not the hospital or such component currently is located at the same site as it was located when it was a public hospital); and does not meet the definition of a converted hospital as described in subsection 32.

32. "Converted hospital" means a hospital that satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; and at any time during the 1999-2000 payment adjustment year, was an eligible hospital meeting the definition of a public hospital as described in subsection 29 (whether or not the hospital currently is located at the same site as it was located when it was a public hospital).

33. "Remained in operation" or "remains in operation" means that, except for closure or other cessation of services caused by natural disasters or other events beyond that hospital's reasonable control (including labor disputes), the hospital was licensed to provide hospital inpatient services, and continued to provide, or was available to provide, hospital inpatient services to Medi-Cal patients throughout the particular time period in question.

34. "Maximum state disproportionate share hospital allotment for California" means, with respect to the 1998 federal fiscal year and subsequent federal fiscal years, that amount specified for California under Section 1396r-4(f) of Title 42 of the United States Code for that fiscal year, divided by the federal medical assistance percentage applicable for federal financial participation purposes for Medi-Cal program expenditures with respect to that same federal fiscal year.

35. "Applicable federal fiscal year" means, with respect to the 2000-01 payment adjustment year and subsequent payment adjustment years, the federal fiscal year that commences on October 1 of the particular payment adjustment year.

36. "Medical assistance increment" means the federal medical assistance percentage applicable for federal financial participation purposes for Medi-Cal program expenditures, expressed as a percentage, less the number one-half, expressed as a percentage.

C. Determination of Payment Amounts

1. Except as otherwise provided in this Attachment, the additional payments will be distributed on a per diem basis. Each eligible hospital will receive a minimum specified payment adjustment which varies based on the type of hospital involved. Further, for some hospitals, a variable per diem amount, based on the hospital's low-income utilization rate, will also be paid.

2. Subject to the limitations in other Sections of this Attachment, the additional amount to be distributed to each hospital shall be determined as follows:

   a. Concurrent with each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the Department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is a major teaching hospital, the hospital shall be paid the sum of all of the following amounts:

      (1) A minimum payment adjustment of three hundred dollars ($300).

      (2) The sum of the following amounts, minus three hundred dollars ($300).

         (A) A ninety dollar ($90) payment adjustment for each percentage point, from 25 percent to 29 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

         (B) A seventy dollar ($70) payment adjustment for each percentage point, from 30 percent to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A fifty dollar ($50) payment adjustment for each percentage point, from 35 percent to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A thirty dollar ($30) payment adjustment for each percentage point, from 45 percent to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A ten dollar ($10) payment adjustment for each percentage point, from 65 percent to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(3) If the sum calculated under subparagraph (2) is less than zero, it shall be disregarded for payment purposes.

b. Concurrent with each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the Department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is a children's hospital, the hospital shall be paid the sum of four hundred fifty dollars ($450).

c. Concurrent with each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the Department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is an acute psychiatric hospital, or an alcohol-drug rehabilitation hospital, the hospital shall be paid the sum of all of the following amounts:

(1) A minimum payment adjustment of fifty dollars ($50).

(2) The sum of the following amounts, minus fifty dollars ($50):

(A) A ten dollar ($10) payment adjustment for each percentage point, from 25 to 29 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(B) A seven dollar ($7) payment adjustment for each percentage point, from 30 to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A five dollar ($5) payment adjustment for each percentage point, from 35 to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A two dollar ($2) payment adjustment for each percentage point, from 45 to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A one dollar ($1) payment adjustment for each percentage point, from 65 to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(3) If the sum calculated under subparagraph (2) is less than zero, it shall be disregarded for payment purposes.

d. Concurrent with each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the Department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital does not meet the criteria for receiving payments under paragraphs a., b., or c. above, the hospital shall be paid the sum of all of the following amounts:

State: California

(1) A minimum payment adjustment of one hundred dollars ($100).

(2) If the hospital is an emergency services hospital at the time the payment adjustment is paid, a two hundred dollar ($200) payment adjustment.

(3) The sum of the following amounts, minus one hundred dollars ($100), and minus an additional two hundred dollars ($200) if the hospital is an emergency services hospital at the time the payment adjustment is paid:

(A) A forty dollar ($40) payment adjustment for each percentage point, from 25 percent to 29 percent, inclusive, of the hospitals low-income number as shown on the disproportionate share list.

(B) A thirty-five dollar ($35) payment adjustment for each percentage point, from 30 percent to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A thirty dollar ($30) payment adjustment for each percentage point, from 35 percent to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A twenty dollar ($20) payment adjustment for each percentage point, from 45 percent to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A fifteen dollar ($15) payment adjustment for each percentage point, from 65 percent to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(4) If the sum calculated under subparagraph (3) is less than zero, it shall be disregarded for payment purposes.

3. When consistent and reliable data are available statewide as determined by the Department of Health Services, the Department may include those acute inpatient hospital days attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department to provide such services.

D. **Limitations**

1. To qualify for payment adjustment amounts under this Attachment, a hospital must have been included on the disproportionate share list for the particular payment adjustment year.

2. For any particular payment adjustment year, no hospital may qualify for payments under more than one category among those in Section C. above.

3. For each eligible hospital, there is a maximum limit on the number or Medi-Cal acute inpatient hospital days for which payment adjustment amounts may be paid for each payment adjustment year. The maximum limit shall be that number of days that equals 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days, as determined from all Medi-Cal paid claims records available through April 1 preceding the beginning of the payment adjustment year. When consistent and reliable data are available statewide as determined by the Department of Health Services, the Department may include those acute inpatient hospital days attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department to provide such services.

4. No payment adjustments under the payment adjustment program shall be payable in connection with claims paid prior to the effective data approved by the federal government for the payment adjustment program.

   No payment adjustments under any amendments to the payment adjustment program shall be payable in connection with claims paid prior to the effective date approved by the federal government for the amendments to the payment adjustment program.

5. Reductions in payment adjustment amounts shall apply when an insufficient amount of funds are available under the terms of the payment adjustment program. Any such reduction must be consistent with the following provisions.

The Department shall compute, prior to the beginning of each payment adjustment year, the projected size of the payment adjustment program for the particular payment adjustment year. To do so, the Department shall determine the projected total payment adjustment amount for each eligible hospital, and shall add these amounts together to determine the projected total size of the program. To the extent this projected total figure for the program exceeds the portion of the maximum state disproportionate share hospital allotment for California under federal law that the Department anticipates will be available for the period in question, the Department shall reduce the total per diem composite amounts of the various eligible hospitals in the fashion described below so that the allotment in question will not be exceeded.

a. All total per diem composite amounts for the entire payment adjustment year shall be reduced proportionately not to exceed two percent of each total per diem composite amount.

b. If the reductions authorized by paragraph a. are insufficient to align the program with the federal allotment for California, then the following shall apply:

(1) The adjusted total per diem composite amounts, as calculated under paragraph a., shall remain in effect for each eligible hospital whose low-income number is 30 percent or more.

(2) The adjusted total per diem composite amounts, as calculated under paragraph a., for all other eligible hospitals shall be further reduced proportionately to align the program with the federal allotment, but in no event to a level that is less than 65 percent of the total per diem composite amount that would have been payable to the eligible hospital had no reductions taken place.

c. If the steps set forth in paragraph b. are not adequate to align the program with the federal allotment, the adjusted total per diem composite amounts for all eligible hospitals for the entire payment adjustment year shall be further reduced proportionately to align the program with the federal allotment, but in no event to a level that would result in adjusted total per diem composite amounts that are less than 65 percent of the total per diem composite amounts that would have been payable had no reductions taken place.

d. At such time as all eligible hospitals have been reduced to the 65 percent level set forth in paragraph b. and paragraph c., the adjusted total per diem composite amounts for all eligible hospitals shall be further reduced proportionately as necessary to align the program with the federal allotment.

e. *~~This subsection 5 shall not apply to the 1995-96 payment adjustment year.~~*

6. ***Mental Health Limitation.***

a. With respect to the 1997-98 payment adjustment year and each subsequent payment adjustment year, the aggregate payment adjustment amount for mental health facilities shall not exceed the lesser of $1,562,298 or 0.071% of the total disproportionate share hospital allotment for the particular payment adjustment year, as required under the provisions of Section 1396r-4(h) of Title 42 of the United States Code.

b. For purposes of this subsection, mental health facilities are institutions for mental disease, psychiatric acute care hospitals, and psychiatric health facilities. Mental health services provided by general acute care hospitals in psychiatric wards, wings, distinct parts, and units are not services provided by a "mental health facility."

c. For purposes of this subsection, mental health services includes acute inpatient and outpatient services provided in a psychiatric acute care hospital, psychiatric health facility, or, for patients under 21 years of age or over 64 years of age, in an institution for mental disease.

7. The data utilized by the Department shall relate to the hospital under present and previous ownership. When there has been a change of ownership, a change in the location of the main hospital facility, or a material change in patient admission patterns during the twenty-four months immediately prior to the payment adjustment year, and the change has resulted in a diminution of access for Medi-Cal inpatients at the hospital as determined by the Department, the Department shall, to the extent permitted by federal law, utilize current data that are reflective of the diminution of access, even if the data are not annual data.

8.* ~~The system of payment adjustments described in the former version of Attachment 4.19A (effective July 1, 1990) will become inoperative as of the approval date of this Attachment.~~*

9.* ~~The payment adjustments under SPA 01-15 are not in consideration for services rendered prior to the effective date approved by HCFA. Such payment adjustments are distributed in conjunction with claims paid on and after the effective date as a mechanism to allocate funds relating to periods of time on and after the effective date.~~*

10. If any payment adjustment that has been paid, or that is otherwise payable, under this Attachment exceeds the hospital-specific limitations set forth in Section J. of this Attachment, the Department shall withhold or recoup the payment adjustment amount that exceeds the limitation. The nonfederal component of the amount withheld or recouped shall be redeposited in, or shall remain in, the fund, as applicable, until used for the purposes described in paragraph (2) of subdivision (j) of Section 14163 of the Welfare and Institutions Code.

11. The payment adjustments under this Attachment shall be limited as specified in other provisions of this Attachment.

State: California

E. Additional Description

1. Except as otherwise provided in this Attachment, the disproportionate share payments shall be distributed concurrent with claims paid on those dates on or after July 1, 1991, for which federal approval is effective and as follows:

   a. *~~For the fiscal year July 1, 1991 through June 30, 1992, the State shall determine which hospitals meet the disproportionate share definition set out in Section A. subsection 2. for the 1991-92 payment adjustment year, and the aggregate per diem payment adjustment amount for each hosptial. As soon as determined, the Department shall issue a disproportionate share list showing the name of each hospital qualifying for payment adjustments, the hospital's Medi-Cal utilization rate and low-income utilization rate, the hosptial's low income number, and the amount of the per diem payment adjustment to be made for each hospital for the 1991-92 fiscal year~~.*

   b. No later than the fifth day of each fiscal year *~~thereafter,~~* the Department shall determine, for the particular payment adjustment year, which hospitals meet the disproportionate share definition set out in Section A., subsection 2. and the aggregate per diem payment adjustment amount for each hospital. When determined, the Department shall issue a disproportionate share list showing the name and license number of each hospital qualifying for payment adjustments, the hospital's Medi-Cal utilization rate and low-income utilization rate, the hospital's low-income number, and the amount of the per diem payment adjustments to be made for each such hospital.

   c. The determinations regarding disproportionate share hospital status and the payments made in accordance with paragraph~~s a. and~~ b. above shall be final determinations and payments. Nothing on a disproportionate share list, once issued by the Department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the State.

State: California

2. Notwithstanding any other provision of this Attachment, to the extent necessary or appropriate to implement and administer the amendments to Section 14105.98 of the Welfare and Institutions Code enacted during the 1994 calendar year, the Department may utilize an approach involving interim payments, with reconciliation to final payments within a reasonable time.

*~~F. Supplemental Lump-Sum Payment Adjustments - September 30, 1993~~

~~1. For the 1993-94 payment adjustment year, each eligible hospital shall also be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being included on the disproportionate share list as of September 30, 1993. For purposes of federal medicaid rules, including Section 447.297(d) of Title 42 of the Code of Federal Regulations, the supplemental payment adjustments shall be applicable to the federal fiscal year that ends on September 30, 1993.~~

~~2. The availability of supplemental payment adjustments under this paragraph shall be determined as follows:~~

~~a. The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1993 federal fiscal year. This final allotment is two billion one hundred ninety-one million four hundred fifty-one thousand dollars ($2,191,451,000), as specified at page 43186 of Volume 58 of the Federal Register.~~

~~b. The total amount of all disproportionate share hospital per diem payment adjustment amounts under this Attachment, whether paid or payable, that are applicable to the 1993 federal fiscal year shall be determined. The applicability of the per diem payment adjustment amounts to the 1993 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.~~*

J. OBRA 1993 Hospital-Specific Limitations

1. General Background

   a. Section 1396r-4(g) of Title 42 of the United States Code, as added by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"), imposes hospital-specific limitations on the amount of federal financial participation available for payment adjustments for the 1994-95 payment adjustment year and subsequent payment adjustment years ("OBRA 1993 limits"). The OBRA 1993 limits are applied on an annual basis, based on the State fiscal year. As described in subsection 5 below, the limits apply to public hospitals for the 1994-95 payment adjustment year, and to all eligible hospitals for the 1995-96 and subsequent payment adjustment years.

   b. Under the OBRA 1993 limits, payment adjustments made to a hospital with respect to a State fiscal year may not exceed the costs incurred by the hospital of furnishing hospital services, net of Medi-Cal payments (other than disproportionate share hospital payment adjustments described at page 18 *et seq.* of this Attachment) and payments by uninsured patients, to individuals who either are eligible for the Medi-Cal program or have no health insurance (or other source of third party coverage) for services provided during the year. Payments made by a State or unit of local government to a hospital for services provided to indigent patients are not considered to be a source of third party payment.

2. General Approach To Calculations/Program Consistency

   a. Definitions

      For purposes of this Section J, the following definitions shall apply:

      (1) "Subject payment adjustment year" means the particular payment adjustment year to which the limitations described in this Section J are being applied.

(2) "Data determination date" means,* ~~with respect to the 1994-95 and 1995-96 payment adjustment years, the date of September 15, 1995~~* For the 1996-97 payment adjustment year and subsequent payment adjustment years, the date of June 15 immediately prior to the beginning of the subject payment adjustment year shall be the "data determination date" with respect to that subject payment adjustment year.

b. To facilitate implementation of the OBRA 1993 limits under the Medi-Cal program, the calculations of costs and revenues shall, except as otherwise provided in this Section J, be determined prior to the beginning of the subject payment adjustment year. For the most part, the data used in the calculations will be obtained through the data collection mechanisms and sources used in the determinations of hospital eligibility and payment adjustment levels under the payment adjustment program for the subject payment adjustment year.

c. In recognition of their unusual nature, three limited elements of Medi-Cal program costs and revenues will be computed based on more recent data than other costs and revenues. These three elements relate to the Medi-Cal Construction Renovation and Replacement Program under Welfare and Institutions Code Section 14085.5 ("CRRP"), the Medi-Cal Administrative Claiming program under Welfare and Institutions Code Section 14132.47 ("MAC") referred to as Medi-Cal Administrative Activities ("MAA"), and the Medi-Cal Targeted Case Management program under Welfare and Institutions Code Section 14132.44 ("TCM").

d. Except as otherwise provided in this Section J, the Department shall calculate the OBRA 1993 limit for each hospital prior to the beginning of the subject payment adjustment year, or as soon thereafter as possible. The calculations for the subject payment adjustment year shall be based only on that data available as of the data determination date, except for CRRP, MAA and TCM data described in the

preceding paragraph, which may include data collected through a survey completed after the data determination date and except for other data as described in this Section J.

e. *~~With respect to the 1994-95 payment adjustment year, the methodology set forth in subsection 4 shall apply except as provided for in subsection 6.~~*

f. Where a federal Medicaid demonstration project under Section 1315(a) of Title 42 of the United States Code is in effect, or may be in effect, during the subject payment adjustment year, the methodology set forth in subsection 4 shall apply, except as provided for in subsection 7.

3. Calculation Of OBRA 1993 Limit - General Methodology

a. With respect to each payment adjustment year referred to in subsection 5 below, the Department shall compute the OBRA 1993 limit for each eligible hospital, based on the data elements referred to below.

b. Except as otherwise provided in paragraph c, ~~or in~~ *~~subsections 6 or 7~~, in determining expenses the Department shall use the data from the annual reports filed by hospitals with OSHPD that are used to structure the payment adjustment program for the subject payment adjustment year. All data from such reports shall be considered to be final for purposes of these calculations as of the February 1 immediately prior to the applicable data determination date for the subject payment adjustment year. For example, for the 1995-96 payment adjustment year, the Department shall use reports relating to the hospital's fiscal year that ended during calendar year 1993. The Department shall use a trend factor to project these expenses into the subject payment adjustment year, as described in subparagraph (1) of paragraph b of subsection 4 below. *~~For the 1994-95 payment adjustment year, the Department shall implement the special rules set forth in subsection 6. Further, where federal demonstration projects are involved, the Department shall implement the special rules set forth in subsection 7.~~*

c. With respect to MAA, TCM, and specified CRRP expenses, the Department shall conduct a survey of affected hospitals to compute such expenses for application of the OBRA 1993 limits relating to the subject payment adjustment year.

d. Except as otherwise provided in paragraph e,* ~~or in subsections [illegible] or [illegible],~~* in calculating revenues the Department shall use data involving Medi-Cal payments made by the Department for hospital services during the calendar year ending six months prior to the beginning of the subject payment adjustment year. For the most part, these data shall be obtained from the data collection mechanisms and sources used to determine the annualized Medi-Cal inpatient paid days referred to in subsection 9 of Section B of this Attachment.
~~For the 1994-95 payment adjustment year, the Department shall implement the special rules set forth in subsection 6. Further, where federal demonstration projects are involved, the Department shall implement the special rules set forth in subsection 7.~~

e. With respect to MAA, TCM, and specified CRRP revenues, the Department shall conduct a survey of affected hospitals to compute such revenues for application of the OBRA 1993 limits relating to the subject payment adjustment year. Surveys shall be conducted at such time that consistent and reliable data, as determined by the Department, is available statewide.

4. Calculation Of OBRA 1993 Limits - Formula To Be Used

The formula set forth below is for purposes of implementing the OBRA 1993 limits. The calculations involve various projections and estimates of hospital revenues and expenses.

a. The formula to be used by the Department for each eligible hospital shall be:

DSH_LMT = MCUN_EX - MCUN_RV

WHERE:

DSH_LMT=the OBRA 1993 hospital-specific limit

MCUN_EX=Medi-Cal/Uninsured Expenses

MCUN_RV=Medi-Cal/Uninsured Revenues

The specific elements yielding MCUN_EX and MCUN_RV are described below in paragraphs b and c, respectively.

b. "Medi-Cal/Uninsured Expenses" (MCUN_EX)

(1) "Projected Adjusted Hospital Operating Expenses" is computed from prior year OSHPD data that are projected ("trended") forward into the subject payment adjustment year. * ~~Except as provided in subsections 6 or 7,~~* the Department shall use the data from the annual reports filed by hospitals with OSHPD that are used to determine eligibility for payments under the program (the "Hospital Disclosure Reports"). All data from such reports shall be considered to be final for purposes of these calculations as of the February 1 immediately prior to the applicable data determination date for the subject payment adjustment year. "Projected Adjusted Hospital Operating Expenses" is the "Total Operating Expenses" (TOT_OP) as reported on the applicable OSHPD report, minus "CRRP Costs" for the same period (CRRP) as determined by the applicable hospital-specific survey, multiplied by the trend factor (TREND).

The computation of the "Projected Adjusted Hospital Operating Expenses" (PR_ADJOP) is expressed as follows:

PR_ADJOP=(TOT_OP-CRRP)xTREND.

The applicable trend factor shall be derived from the Medicare hospital input price index ("Medicare hospital market basket"), developed

by the Health Care Financing Administration and forecasted by Data Resources, Inc./McGraw Hill. *~~Except as provided in subsection 6~~* the trend factor shall equal the product of the Medicare hospital market basket percentage increases that were forecasted and published in the Federal Register for the three most recent federal fiscal years ("FFY") in conjunction with the annual "Medicare Program Changes to Hospital Inpatient Prospective Payment Systems and Rates" promulgated (or proposed, where final rules have not yet been promulgated) as of the applicable data determination date for the subject payment adjustment year. The earliest of the particular Medicare hospital market basket percentage increases used shall be multiplied by an adjustment factor to account for varying hospital OSHPD reporting periods. The applicable adjustment factor will depend on the particular month in which a hospital's OSHPD data reporting period ends, as follows:

OSHPD Reporting Period Ending	Adjustment Factor
Jan	1.417
Feb	1.333
Mar	1.250
Apr	1.167
May	1.083
Jun	1.000
Jul	.917
Aug	.833
Sep	.750
Oct	.667
Nov	.583
Dec	.500

For example, with respect to the 1995-96 payment adjustment year, the three applicable Medicare hospital market basket percentage increases are 4.3% (final federal figure for FFY 1994, 58 Fed.Reg. 46270), 3.6% (final federal figure for FFY 1995, 59 Fed.Reg. 45330), and 3.5% (final federal figure for FFY 1996, 60 Fed.Reg. 45778), as promulgated in the Federal Register on or before September 15, 1995. The applicable trend factor for the 1995-96 payment adjustment year is therefore computed as:

TREND = [1 + (.043 x 1.00*)] x 1.036 x 1.035.
*(Adjustment factor, for the earliest of the federal figures used (FFY 1994), for hospital with OSHPD data reporting period ending in June 1993.)

For a hospital with an OSHPD data reporting period ending in March 1993, the trend factor applicable for the 1995-96 payment adjustment year is computed as:

TREND = [1 + (.043 x 1.250*)] x 1.036 x 1.035.
*(Adjustment factor, for the earliest of the federal figures used (FFY 1994), for hospital with OSHPD data reporting period ending in March 1993.)

(2) "CRRP Costs" (CRRP_EX) derived from the applicable hospital-specific survey (which costs shall be limited to applicable depreciation, interest and, to the extent such costs are reflected in the debt service amounts recognized under Welfare and

Institutions Code Section 14085.5, the following other federally recognized capital-related costs as described in Title 42 of the Code of Federal Regulations, Section 413.130: taxes, costs of betterments and improvements, costs of minor equipment, insurance, debt issuance costs, debt discounts and debt redemption costs) are added to the "Projected Adjusted Hospital Operating Expenses," and "MAA Costs" (derived from the applicable hospital-specific survey) are subtracted, to arrive at the "Projected Total Hospital Expenses" for the subject payment adjustment year.

The computation of the "Projected Total Hospital Expenses" (PR_TOTEX) is expressed as follows:

PR_TOTEX = PR_ADJOP + CRRP_EX - MAA.

(3) A "Medi-Cal/Uninsured Patient Mix" ratio is applied to the "Projected Total Hospital Expenses." The "Medi-Cal/Uninsured Patient Mix" ratio is the ratio of all gross inpatient and outpatient charges (including charges associated with services provided under the Medi-Cal/Short-Doyle program, the San Mateo/Santa Barbara Health Initiative and other managed care programs) attributable to Medi-Cal patients, the County Indigent Program, and uninsured patients to total gross inpatient and outpatient charges. The necessary data elements are extracted from the applicable OSHPD report, the Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes, and the MEDS and OSHPD Confidential Discharge Data files.

The computation of the "Medi-Cal/Uninsured Patient Mix" ratio (MCUN_MIX) is as follows:

MCUN_MIX = (MCCRG + COINDCRG + UNINSCRG) ÷ (TOTIPCRG + TOTOPCRG).

WHERE:

MCCRG = Total Medi-Cal inpatient and outpatient charges (including charges associated with services provided under Medi-Cal managed care programs);

COINDCRG = Total County Indigent Program inpatient and outpatient charges;

UNINSCRG = Total charges attributable to uninsured patients;

TOTIPCRG = Total inpatient charges; and

TOTOPCRG = Total outpatient charges.

* ~~Projected "demonstration project expenses" (DEMO EX) are determined based on the terms and conditions of an approved federal Medicaid demonstration project, but only to the extent set forth in paragraph b of subsection 7. DEMO EX is added to the product of PR TOTEX and MCUN MIX to determine "Medi-Cal/Uninsured Expenses."~~*

The computation of "Medi-Cal/Uninsured Expenses" (MCUN_EX) is therefore expressed as follows:

MCUN_EX = PR_TOTEX x MCUN_MIX + DEMO EX.

c. "Medi-Cal/Uninsured Revenues" (MCUN_RV) is comprised of the following components:

(1) "Medi-Cal Inpatient Revenues" (MIP_RV).

Except as otherwise provided in this Section J, "Medi-Cal Inpatient Revenues" shall be equal to the revenues for inpatient services, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the calendar year ending prior to the beginning of the subject

payment adjustment year. The revenue data shall be obtained from the data collection mechanisms and sources used by the Department in determining the hospital's annualized Medi-Cal inpatient paid days (as referred to in subsection 9 of Section B of this Attachment) as well as other applicable data maintained by the Department relating to Medi-Cal payments made during the same calendar year time period. These data sources are the Medi-Cal paid claims tapes, Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes and other managed care plan payment data. (This step does not include payments under Welfare and Institutions Code Section 14085.6, which are addressed in subparagraph (4) below. *~~It also does not include certain demonstration project revenues, as described in subsection 7 below. For special rules regarding the 1994-95 payment adjustment year, see subsection 6 below.)~~*

(2) "Medi-Cal Outpatient Revenues" (MOP_RV).

Except as otherwise provided in this Section J, "Medi-Cal Outpatient Revenues" shall be equal to Medi-Cal revenues for outpatient services, regardless of dates of services, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the calendar year ending prior to the beginning of the subject payment adjustment year. The revenue data shall be obtained from the data collection mechanisms and sources used by the Department in determining the hospital's annualized Medi-Cal inpatient paid days (as referred to in subsection 9 of Section B of this Attachment) as well as other applicable data maintained by the Department relating to Medi-Cal payments made during the same calendar year time period. These data sources are the Medi-Cal paid claims tapes, Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes, and other managed care plan

payment data. *~~(This step does not include certain demonstration project revenues, as described in subsection 7 below. For special rules regarding the 1994-95 payment adjustment year, see subsection 6 below.)~~*

(3) "CRRP Revenues" (CRRP_RV).

"CRRP Revenues" will be determined based on the results of the applicable hospital-specific survey.

(4) "Emergency Services/Supplemental Payments Revenues" (EMS_RV).

(a) *~~Except as provided for in clause (d) or in subsection 7~~* the Department shall determine the hospital's revenue amount relating to the program under Welfare and Institutions Code Section 14085.6 ("S.B. 1255 program"), with respect to services to be rendered during the subject payment adjustment year, based on the best information available as of the data determination date, in the fashion described below.

(b) In determining the S.B. 1255 revenue amount to be included for the subject payment adjustment year, the Department shall use, in the following order of availability, the amount that:

(i) Is set forth in any contract between the hospital and the State as negotiated by the California Medical Assistance Commission ("CMAC") pursuant to Section 14085.6;

(ii) Has been agreed upon by the particular hospital and CMAC staff, but has not yet been formally approved by CMAC or by the hospital;

(iii) Represents the latest offer made by CMAC staff to the particular hospital; or,

(iv) The hospital was granted with respect to the payment adjustment year immediately prior to the subject payment adjustment year, but only if (1) subclause (i), (ii), or (iii) do not apply, and (2) the hospital has communicated to CMAC an intent to participate in the S.B. 1255 program for the subject payment adjustment year. Should this clause (iv) apply for a hospital, the amount included by the Department shall not exceed the amount of S.B. 1255 program payments the hospital has requested from CMAC for the subject payment adjustment year.

(c) In the event that none of the data described in clause (b) is available as of the data determination date, the Department shall assume that the S.B. 1255 program revenue for the particular hospital for the subject payment adjustment year will be the amount the hospital was granted with respect to the payment adjustment year immediately prior to the subject payment adjustment year. The Department, in cooperation with CMAC, shall notify hospitals of the existence and potential applicability of this provision at the time the S.B. 1255 program is initiated each year.

*~~(d) With respect to the 1994-95 and 1995-96 payment adjustment years, the Department shall take into account, except as otherwise provided in subsection 7, the~~ particular Medi-Cal contract amendment(s) ~~for S.B. 1255 program payments effective for each period that have been entered into at the time that the computations pursuant to this Section J are made for each of the respective subject payment adjustment years.~~ *

(e) For purposes of clauses (b), (c)* ~~and (d)~~ above, the Department shall use the contracted amount when the contracted "days of service" are equal to or less than 12 months. In the event that the "days of service" extend beyond 12 months, the Department shall reduce the total contract amount to reflect 12 months of revenue by dividing the total contract amount by the number of months represented in the contracted "days of service" and multiplying that number by 12.

(f) *~~Except as provided in subclause (iv)~~*, for the 1996-97 payment adjustment year and subsequent payment adjustment years, if a hospital meets the conditions set forth in subclause (i), the Department shall take into account additional S.B. 1255 revenue amounts pursuant to subclauses (ii) and (iii).

(i) The hospital entered into a Medi-Cal contract amendment(s) since the last data determination date (September 15, 1995 and thereafter) that resulted in S.B. 1255 program payments to the hospital relating to services rendered in a fiscal year preceding the subject payment adjustment year, and such S.B. 1255 program payments were not included in the OBRA 1993 limit calculation for the year(s) during which such services were rendered.

(ii) The Department shall determine whether the inclusion of the additional S.B. 1255 program revenue described in subclause (i) would have resulted in a reduction in the hospital's disproportionate share payment amounts for the payment adjustment year for which the additional S.B. 1255 program payments were received.

(iii) To the extent that the additional S.B. 1255 revenue described in subclause (i) would have reduced the hospital's OBRA 1993 limit in an amount that would have resulted in the hospital surpassing its OBRA 1993 limit for a previous payment adjustment year, the amount of the additional S.B. 1255 revenue that would have caused the hospital to surpass its OBRA 1993 limit for any such prior year shall be added to the S.B. 1255 revenue amount for the subject payment adjustment year as determined under clauses (b)-(e).

* ~~(iv) Subclauses (i) through (iii) shall not apply to a hospital participating in a federal Medicaid demonstration project, if such demonstration project provides a repayment arrangement agreed to by the parties regarding disproportionate share payment adjustment amounts.~~ *

(5) "Targeted Case Management Revenues" (TCM_RV).

"Targeted Case Management Revenues" will be determined based on the results of the applicable hospital-specific survey.

(6) "Uninsured Cash Payments" (UNINS_RV).

Except as otherwise provided in this Section J, "Uninsured Cash Payment" will be derived from the applicable OSHPD report (as referred to in paragraph b of subsection 3). "Uninsured Cash Payments" shall be calculated as the sum of the inpatient and outpatient net revenues reported for "Other Payors" on page 12 of the OSHPD report. Consistent with section 1396r-4(g) of Title 42 of the United States Code, such sum shall not include payments made by the State, the University of California or a unit of local government to the hospital for services provided to indigent patients. The amount so determined from the applicable OSHPD report will be trended forward into the subject payment adjustment year (as referred to in subparagraph (1) of paragraph b of subsection 4).

(7) * ~~Projected "demonstration project revenues" (DEMO RV) are determined based on the terms and conditions of an approved federal Medicaid demonstration project, but only to the extent set forth in paragraph b of subsection 7.~~*

In addition to the above revenue sources, the Department will take into account, as may be required by the DSH methodology in effect in 2004-05, all other supplemental payments applicable to the OBRA 1993 calculation.

`The computation of "Medi-Cal /Uninsured Revenues" (MCUN_RV) plus any other supplemental payments is therefore expressed as follows:

MCUN_RV = MIP_RV + MOP_RV + CRRP_RV + EMS_RV + TCM_RV + UNMS_RV + ~~DEMO RV~~ OTHER.

5. Application of limit

~~a.~~ * ~~For the 1994-95 payment adjustment year, the OBRA 1993 limits shall apply only to public hospitals. With respect to the 1994-95 payment adjustment year, the total disproportionate share payment adjustment amounts described at page 18 et seq. of this Attachment paid or payable to each eligible hospital that is owned or operated by the State (or by an instrumentality or a unit of government within the State) shall not exceed 100% of the hospital's OBRA 1993 limit as calculated pursuant to this Section J with respect to the subject payment adjustment year; provided, however, that payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 200% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year.~~*

b. For the 1995-96 and subsequent payment adjustment years, the OBRA 1993 limits shall apply to all eligible hospitals. With respect to any particular payment adjustment year, no eligible hospital shall receive total payment adjustment amounts under this Attachment in an amount that exceeds 100% of the hospital's OBRA 1993 limit as calculated pursuant to this Section J with respect to the subject payment adjustment year;* except ~~as follows: (1) with respect to the 1997-98 and 1998-99 payment adjustment years,~~ the payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 175% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year;* ~~and (2) with respect to the 1999-2000 payment adjustment year and subsequent payment adjustment years, the payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396-4(g)(2) of the Title 42 of the United States Code) shall be limited to 100% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year, unless federal law sets forth or authorizes a different percentage figure or amount to be used for such hospitals for such purposes for the subject payment adjustment year, in which case such different percentage figure or amount shall apply for such hospital for such payment adjustment year.~~

c. * ~~For the 1995-96 payment adjustment year, the OBRA 1993 limits shall be applied as set forth in subparagraph (3) of paragraph e of subsection 1 of Section I of this Attachment. For subsequent payment adjustment years,~~ the OBRA 1993 limits shall be applied with respect to each year after performing computations under subsection 5 of Section D of this Attachment and as specified in other provisions of this Attachment. The OBRA 1993 limits shall be applied to the amounts computed for all affected hospitals prior to the computations of transfer amounts under Section 14163 of the Welfare and Institutions Code.

d. Where a payment adjustment amount that is otherwise paid or payable to an eligible hospital under this Attachment is; or would be, above the limits described in this Section J, the payment adjustment amount shall be subject to the provisions of subsection ~~9~~ 10 of Section D of this Attachment.

* ~~6. Special Rules relating to 1994-95 Payment Adjustment Year.~~

* ~~With respect to the 1994-95 payment adjustment year, the OBRA 1993 limit shall be calculated for each eligible hospital in accordance with the methodology set forth~~ in ~~subsection 4 above, except as follows.~~

* ~~a. In determining expenses pursuant to paragraph b of subsection 4 (other than MAA and CRRP expenses), the Department shall use data from the annual OSHPD reports filed by hospitals for fiscal periods ending during the 1993 calendar year.~~

* ~~b. The applicable Medicare hospital market basket percentage increases, as referred to in subparagraph (1) of paragraph b of subsection 4 shall be 4.3% and 3.6% for FFY 1994 and FFY 1995, respectively (58 Fed.Reg. 46270; 59 Fed.Reg.45330). The Medicare hospital market basket percent increase for FFY 1994 shall be adjusted for varying hospital OSHPD reporting periods, as specified in subparagraph (1) of paragraph b of subsection 4.~~

State: California

~~b. This paragraph b shall apply only where the federal government has approved a demonstration project, the federal approval has been issued prior to the data determination date for the subject payment adjustment year, and some or all of the federally approved effective dates of the project fall within the subject payment adjustment year. In such situations, to the extent that the Department determines (with concurrence of HCFA) that the terms and conditions of an approved federal Medicaid demonstration project constitute federally approved variations from the provisions of this Section J (including expenses, calculations, data elements, data collection and revenues federally recognized under the demonstration project for the computation of the OBRA 1993 limits hereunder), such terms and conditions of the approved demonstration project shall govern.~~

8. Department's Discretion

a. Notwithstanding any other provision of this Section J, but subject to paragraph b, below, the Department shall (with concurrence of HCFA) have the discretion to vary the mechanisms and sources, or formulas specified herein if the department finds that such variance is required to:

(1) Comply with federal law or regulations,

(2) Take into account the unavailability of particular data elements, or the impracticality of making a particular calculation, or

(3) Avoid inequitable or unintended results not consistent with OBRA 1993 or with the overall purpose and intent of this Section J.

b. A variance pursuant to paragraph a will be limited to making minor or insignificant adjustments to any formula, calculation, or methodology specified in this Section J, or to the specified sources of data to be used in any such formula, calculation, or methodology. These minor adjustments will be limited to instances when the format for reporting data used by the *Department has been changed by the agency responsible for issuing the* report, or when the information in an agency's report is incomplete and comparable information is available from the agency. Any minor adjustment made pursuant to this Section J will be made prior to the final calculation of OBRA '93 limits, and will not be made to effect a retroactive adjustment. A variance under this Section J will not be made to correct errors in data

submitted by a reporting hospital to the agency responsible for issuing the particular report, or to make any other correction, change, or adjustment in the data reported by a particular hospital. A variance under this Section J will not be made to alter the fundamental structure or general scheme of this Section J; where significant changes in the formulas, calculations, or methodologies specified in this Section J are necessary, the Department will submit a state plan amendment to the Health Care Financing Administration in the normal course.

9. Department Certification

The Department certifies that it is meeting the requirements of section 1923(g) of the Social Security Act (as added by the Omnibus Budget Reconciliation Act of 1993) by applying the methodology set forth in this Section J. Further, the Department assures that it does not exceed the federal allotment for California set forth at section 1923(f) of the Act.

* ~~the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this subparagraph, shall also be used for all purposes relating to descending pro rata distributions under subparagraph (8).~~

* ~~(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.~~

* ~~g. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before June 30, 2001.~~

P. **Payment Adjustment Program for 2001-02 Payment Adjustment Year and Subsequent Payment Adjustment Years.**

With respect to the 2001-02 payment adjustment year and each subsequent payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

1. Non-Supplemental Payment Adjustments - July 1 - September 30.

   No payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 2001-02 payment adjustment year and each subsequent payment adjustment year.

2. Non-Supplemental Payment Adjustments - October 1 - June 30.

   Payment adjustments with respect to the period October 1 through June 30 of the 2001-02 payment adjustment year and each subsequent payment adjustment year (exclusive of the supplemental lump-sum payment adjustments provided for under subsection 3.), shall be structured as set forth below.

   a. The Department shall determine the maximum state disproportionate share hospital allotment for California for the applicable federal fiscal year under the provisions of applicable federal Medicaid rules.

b. The initial maximum size of the payment adjustment program for the period October 1 through June 30 of each applicable payment adjustment year shall be set at one billion six hundred million dollars ($1,600,000,000), exclusive of any supplemental payment adjustments under subsection 3.

c. The Department shall compute the projected total payment adjustment amounts for all eligible hospitals for the applicable payment adjustment year, exclusive of any supplemental payment adjustments under subsection 3., by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days. For purposes of this paragraph, such determinations shall be made without regard to the OBRA 1993 payment limitations. Notwithstanding the foregoing, with respect to a hospital that, as of July 1 of the applicable payment adjustment year, meets the definition of a converted hospital, the amount otherwise determined under this paragraph shall be reduced as necessary so as not to exceed the total amount of all payment adjustment amounts payable to the hospital under this Attachment for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

d. The computed amount referred to in paragraph c. for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the Department has computed for the particular hospital for the applicable payment adjustment year.

e. Where the computed amount referred to in paragraph c. for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under paragraph c. shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of paragraph g.

f. Where the computed amount referred to in paragraph c. for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in paragraph c. shall be used for purposes of paragraph g.

g. The amounts determined under paragraphs e. and f. for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the period October 1 through June 30 of the applicable payment adjustment year, exclusive of any supplemental payment adjustments under subsection 3.

h. The Department shall increase or decrease the amount determined for each eligible hospital under paragraph e. or f., as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the period October 1 through June 30 of the applicable payment adjustment year. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph b. by the aggregate sum determined under paragraph g. In no case, however, shall the amount determined for a hospital under paragraphs e. or f. be increased such that it would exceed the OBRA 1993 payment limitation for the hospital, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amounts for all hospitals equals the amount set forth in paragraph b.

i. The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph h. shall be further adjusted as follows:

(1) Nonpublic/converted hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic/converted hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic/converted hospital adjustment factor." The applicable adjustment factor shall be 0.835; except, however, where the hospital also meets the definition of a major teaching hospital as of July 1 of the applicable payment adjustment year, the applicable adjustment factor shall be the lesser of 1.00, or that which is necessary to result in an amount for the particular hospital equal to thirty-five million eight hundred thousand dollars ($35,800,000).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(2) Converted Hospitals.

(a) For each eligible hospital that meets the definition of a converted hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The maximum OBRA 1993 limit percentage that is applicable to the hospital for the applicable payment adjustment year pursuant to subsection 5. of Section J. shall be subtracted from 175 percent (the maximum percentage that was applicable to the hospital as a public hospital during the 1999-2000 payment adjustment year).

(ii) The converted hospital adjustment factor shall be that figure derived in subclause (i), expressed as a fraction, subtracted from 1.00.

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply.*** In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(3) Nonpublic Hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amount determined under paragraph h. for each nonpublic hospital described above shall be added together.

(ii) The amount identified in paragraph b. shall be divided by 2.237.

(iii) The resulting figure in clause (ii) shall be increased by an amount equal to the product of the medical assistance increment multiplied by the maximum amount identified in paragraph a.

(iv) The amount derived under clause (iii) shall be reduced by the following:

(I) the sum of the amounts determined for all nonpublic/converted hospitals under subparagraph (1); and

(II) the sum of that portion of the amount determined for any converted hospital under subparagraph (2) that is in excess of that amount equal to 31 percent of all payment adjustment amounts that were payable to the hospital for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

(v) The amount computed under subclause (iv) shall be divided by 2, and the result thereof further reduced by the amount of thirty-three million five hundred thousand dollars ($33,500,000).

(vi) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (v) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have

been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (v) of clause (a).

(4) Public Hospitals.

(a) For each eligible hospital that meets the definition of a public hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph h. for each public hospital described above shall be added together.

(ii) The amount identified in paragraph b. shall be reduced by the sums of the amounts determined for all nonpublic/converted hospitals under subparagraph (1) and all converted hospitals under subparagraph (2), and the sum of the amounts determined for all nonpublic hospitals under subparagraph (3).

(iii) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (ii) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have

been allocated to the particular hospital shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all public hospitals equals the amount derived in subclause (II) of clause (a).

j. If the Mental Health Limitation specified in subsection 6. of Section D. is applicable for the payment adjustment year, the amount computed under paragraph i. for each mental health facility shall be reduced on a pro-rata basis to the extent the aggregate payment for mental health facilities computed under paragraph i. exceeds the limitation in subsection 6. of Section D. the amount so reduced shall be used for purposes of paragraph k.

k. The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1 through June 30 of the applicable payment adjustment year shall be distributed to the hospital in 8 equal installments, each payable as of the last day of each month from October through May of the applicable payment adjustment year. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month. To the extent that any hospital of either of the hospital types described in subparagraph (3) or (4) of paragraph i. is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1 through June 30 of the applicable payment adjustment year, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30 of the applicable payment adjustment year.

l. If, with respect to the 2001-02 payment adjustment year or any subsequent payment adjustment year, the amount identified for California for the applicable federal fiscal year pursuant to Section 1396r-4(f) of Title 42 of the United States Code exceeds the amount of eight hundred seventy-seven million dollars ($877,000,000), the Department shall implement the provisions of paragraphs a. through j. with respect to the applicable payment adjustment year as modified below.

(1) The Department shall determine the maximum state disproportionate share hospital allotment for California under the provisions of applicable federal Medicaid rules.

(2) The Department shall calculate the maximum state disproportionate share hospital allotment for California, by substituting in the calculation the amount of eight hundred seventy-seven million dollars ($877,000,000), as though that amount was identified for California for the applicable federal fiscal year pursuant to Section 1396r-4(f) of Title 42 of the United States Code.

(3) The amount determined under subparagraph (2) shall be subtracted from the amount determined under subparagraph (1).

(4) For purposes of the calculations set forth in paragraph h. regarding each hospital's tentative adjusted projected total payment adjustment amount, the initial amount as set forth in paragraph b. shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (3).

(5) The difference derived in subparagraph (3) shall be divided by the amount determined in subparagraph (2).

(6) For purposes of the determination made under clause (a) of subparagraph (1) of paragraph i. regarding nonpublic/converted hospitals that also meet the definition of a major teaching hospital, the amount of thirty-five million eight hundred thousand dollars ($35,800,000) as specified therein shall be multiplied by a number equal to the sum of the fraction derived in subparagraph (5) plus the number 1.00.

(7) The fraction derived in subparagraph (5) shall be multiplied by 1.226, and the result thereof added to 1.00, yielding a factor for purposes of modifying the determination of the applicable nonpublic hospital adjustment factor pursuant to subparagraphs (8) and (9).

(8) The amount derived under subclause (ii) of clause (a) of subparagraph (3) of paragraph i shall be multiplied by the factor derived in subparagraph (7) prior to the application of the increase set forth in subclause (iii) of clause (a) of subparagraph (3) of paragraph i., as such increase is modified by subparagraph (9) below.

(9) The increase that is applied in subclause (iii) of clause (a) of subparagraph (3) of paragraph i. shall be equal to the product of the medical assistance increment multiplied by the maximum amount derived in subparagraph (2).

(10) For purposes of the calculations set forth in clause (a) of subparagraph (4) of paragraph i. regarding the determination of the applicable public hospital adjustment factor, the initial amount as set forth in paragraph b. shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (3).

m. No eligible hospital shall receive total payment adjustments for the applicable payment adjustment year in excess of the hospital's OBRA 1993 payment limitation as computed by the Department pursuant to Section J.

n. The aggregate sum of the final adjusted projected total payments adjustment amounts computed under paragraph i. ***and j.*** for each eligible hospital for the period October 1 through June 30 of the applicable payment adjustment year shall be the maximum size of the payment adjustment program for the entire payment adjustment year, exclusive of the supplemental payment adjustments provided for under subsection 3.

3. Supplemental Lump-Sum Payment Adjustments - June 30.

a. For the 2001-02 payment adjustment year and each subsequent payment adjustment year, eligible hospitals that meet the requirements of this subsection and that are in operation as of June 30 of the applicable payment adjustment year shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1 through June 30 of the applicable payment adjustment year.

b. The availability of supplemental lump-sum payment adjustments under this subsection shall be determined as follows:

(1) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal Medicaid rules shall be identified for the applicable federal fiscal year.

(2) The total amount of all payment adjustment amounts under this Attachment (exclusive of any payments under this subsection) applicable to the applicable federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the federal fiscal year shall be determined in accordance with federal Medicaid rules.

(3) The figure determined under subparagraph (2) shall be subtracted from the figure identified under subparagraph (1). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subsection.

(4) The maximum amount of supplemental lump-sum payment adjustments under this subsection shall be the positive remainder derived in subparagraph (3).

c. For purposes of supplemental lump-sum payment adjustments under this subsection, only hospitals that can be categorized into either of the two groups specified in subparagraphs (1) and (2) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(1) "Public hospitals," which shall include all eligible hospitals that, as of July 1 of the applicable payment adjustment year, met the definition of a public hospital.

(2) "Nonpublic hospitals," which shall include all eligible hospitals that, as of July 1 of the applicable payment adjustment year, met the definition of a nonpublic hospital.

d. The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under paragraph b. shall first be allocated between the two groups of hospitals referred to in paragraph c. as follows:

(1) "Public hospitals": 75.00% of that amount which is equal to the maximum amount identified in subparagraph (4) of paragraph b. of this subsection 3.

(2) "Nonpublic hospitals": That amount equal to the maximum amount identified in subparagraph (4) of paragraph b. of this subsection 3 less the amount allocated to public hospitals determined under subparagraph (1)

e. The amount of funds allocated pursuant to paragraph d. shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(1) The Department shall identify for each eligible hospital the total amount of payment adjustments under this Attachment (exclusive of any payments under this subsection) applicable to the payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal Medicaid rules.

(2) The amount identified for each hospital under subparagraph (1) shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the Department has computed for the particular hospital for the applicable payment adjustment year.

(3) Where the amount computed under subparagraph (1) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount computed under subparagraph (1) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (1) shall be used for purposes of subparagraphs (5) through (8).

(5) The amounts identified under subparagraph (4) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5) for the particular group, yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum portion of the funds allocated to the particular group under paragraph d., to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Notwithstanding the foregoing, however, in the case of a nonpublic hospital that, as of July 1 of the applicable payment adjustment year, met the definition of a children's hospital, such pro rata share otherwise determined shall be multiplied by a factor of 1.69, yielding a modified pro rata share to be applied only with respect to the first one million dollars ($1,000,000) of the funds allocated pursuant to subparagraph (2) of paragraph d., and, with respect to the remainder of the funds so allocated, the pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share to be applied. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this subparagraph, shall also be used for all purposes relating to descending pro rata distributions under subparagraph (8).

(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

f. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before June 30 of the applicable payment adjustment year.

* ~~g. With respect to the 2001-02 payment adjustment year, supplemental lump-sum payment adjustments shall be determined and payable in conformance with the provisions of paragraph a. through f., except as set forth below.~~