

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
09-004

2. STATE
CA

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2009

5. TYPE OF PLAN MATERIAL (*Check One*):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
Title 42 of the Code of Federal Regulations (CFR) Part 413
Provider Reimbursement Manual (CMS Pub 15-1)
OMB Circular A-87

7. FEDERAL BUDGET IMPACT:
FFY 2008-2009 \$27,715,500
FFY 2009-2010 \$55,431,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 11 to Attachment 4.19-B, pgs. 1-3
Attachment 4.19-A, pgs. 38-40
Attachment 4.19-B, pgs. 21-25

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Attachment 4.19-A, pgs 38-40
Attachment 4.19-B, pgs 21-25

10. SUBJECT OF AMENDMENT:
Supplemental Reimbursement for Medi-Cal Mental Health Services

11. GOVERNOR'S REVIEW (*Check One*):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
The Governor's Office does not
wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Toby Douglas

14. TITLE:

Chief Deputy Director

15. DATE SUBMITTED:

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:



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



DAVID MAXWELL-JOLLY
Director

ARNOLD SCHWARZENEGGER
Governor

March 30, 2009

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations, Region IX
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

STATE PLAN AMENDMENT NO. 09-004A & B

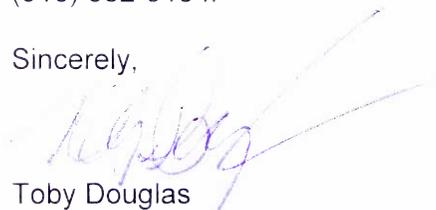
Dear Ms. Nagle:

The Department of Health Care Services (DHCS) is submitting the enclosed State Plan Amendment (SPA) for Short-Doyle/Medi-Cal acute inpatient services and Short-Doyle/Medi-Cal outpatient, rehabilitation, case management and other services. This SPA also allows supplemental reimbursement to an eligible governmental entity for the provision of mental health services to Medi-Cal beneficiaries. This SPA will make changes to California's Medicaid State Plan under Title XIX of the Social Security Act.

The primary purpose of SPA 09-004A & B is to update the reimbursement methodology for specific services under the Short-Doyle/Medi-Cal program and to allow DHCS to reimburse governmental entities for their uncompensated mental health services costs for providing services in one or more of its publicly owned and operated facilities or through a County mental health plan contractor. While some of the details of this SPA may change as DHCS, the Department of Mental Health, and the counties continue discussions with CMS, the effective date of the SPA will be January 1, 2009.

If you have any questions or concerns regarding the proposed provisions, please contact Ms. Barbara Bailey, Chief, Benefits, Waivers Analysis and Rates Division at (916) 445-8689, or Ms. Nancy Hutchison, Chief, Safety Net Financing Division at (916) 552-9154.

Sincerely,


Toby Douglas
Chief Deputy Director
Health Care Programs

Enclosure

cc: See Next Page

Director's Office

1501 Capitol Ave., MS 0000, Sacramento CA 99859-7413
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Internet Address: www.dhcs.ca.gov

Ms. Gloria Nagle
March 30, 2009
Page 2

cc: Ms. Denise Arend, Deputy Director
Community Services Division
Department of Mental Health
1600 Ninth Street
Sacramento, CA 95814

Mr. Frank Vanacore, Deputy Director
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Ms. Nancy Hutchison, Chief
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

SUPPLEMENTAL REIMBURSEMENT FOR MEDI-CAL MENTAL HEALTH SERVICES

This program provides supplemental reimbursement for an eligible governmental entity which meets specified requirements and provides mental health services to Medi-Cal beneficiaries.

Supplemental reimbursement under this program is available only for allowable costs that are in excess of other Medi-Cal revenue the eligible governmental entity receives for mental health services. Eligible governmental entities must provide certification to the state that they have made a total funds expenditure and that the amount claimed is eligible for federal financial participation (FFP).

A. Definition of an Eligible Governmental Entity

A governmental entity is determined eligible if it is a county, a city and county, or the University of California and if it meets either or both of the following requirements:

1. Provides mental health services to Medi-Cal beneficiaries in one or more of its publicly owned and operated facilities.
2. Provides mental health services as a mental health plan (MHP) or through a MHP contractor.

B. Supplemental Reimbursement Methodology

Supplemental reimbursement provided by this program to an eligible governmental entity will consist of FFP for Medi-Cal uncompensated mental health care costs. The supplemental reimbursement methodology is as follows:

1. As described in Section C, the expenditures certified by the eligible governmental entity to the State will represent the payment eligible for FFP. Allowable certified public expenditures will determine the amount of FFP claimed.
2. In no instance will the amount certified pursuant to paragraph C.1, when combined with the amount received for mental health services pursuant to any other provision of this State Plan or any Medicaid waiver granted by the Centers for Medicare and Medicaid Services

TN 09-004

Supercedes

TN: N/A

Approval Date: _____

Effective Date: January 1, 2009

exceed 100 percent of the allowable costs for such mental health services.

3. Pursuant to paragraph C.1, the eligible governmental entity will certify to the Department, on an annual basis, the amount of its eligible uncompensated care costs for providing Medi-Cal mental health services. The supplemental Medi-Cal reimbursement received pursuant to this segment of the State Plan will be distributed in one or more lump-sum payments after submission of such annual certification.
4. Costs for mental health services that are otherwise payable by or reimbursable under the prospective payment reimbursement for federally qualified health centers and rural health clinics set forth earlier in this Attachment, or the cost-based reimbursement methodology set forth in Supplement 5 to this Attachment, are not eligible as certified public expenditures under this supplemental reimbursement methodology.
5. Mental health costs for the subject year that are certified pursuant to paragraph C.1 will be computed in a manner consistent with Medicare cost principles regarding allowable costs, and will only include costs that satisfy applicable Medicaid requirements.
6. Supplemental reimbursement for mental health costs will be determined from cost reports submitted to the Department less any applicable revenue, including Medi-Cal payments, and third party payments and co-payments made by or on behalf of Medi-Cal patients. The data used for the computations will come from the completed cost report for the year of service that is provided by each eligible governmental entity, or from the 2552-96 Medi-Cal cost report, as appropriate.
7. After completion of its audits, the State will reconcile cost information from filed cost reports to cost information from audited cost reports. In addition, the State will reconcile actual expenditures and payments to any amounts used initially to determine the supplemental payment. When any reconciliation results in an underpayment or overpayment to a facility, no less than annually the State will adjust the affected eligible governmental entity's supplemental payment.

C. Responsibilities and Reporting Requirements of the Eligible Governmental Entity

An eligible governmental entity must do all of the following:

TN 09-004

Supercedes

TN: N/A

Approval Date: _____

Effective Date: January 1, 2009

1. Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations that the claimed expenditures for mental health services made by the eligible governmental entity are eligible for FFP.
2. Provide evidence supporting the certification as specified by the Department.
3. Submit data as specified by the Department to determine the appropriate amounts to claim as expenditures qualifying for FFP.
4. Keep, maintain and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible County's are entitled, and any other records required by the Centers for Medicare & Medicaid Services.

D. Department's Responsibilities

1. The Department will submit claims for FFP for the expenditures for services that are allowable expenditures under federal law.
2. The Department will, on an annual basis, submit any necessary materials to the federal government to provide assurances that FFP will include only those expenditures that are allowable under federal law.

State/Territory California

| Citation | Condition or Requirement |
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REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL

OUTPATIENT, REHABILITATIVE, CASE MANAGEMENT AND OTHER SERVICES

The policy of the State Agency is that reimbursement for Short-Doyle/Medi-Cal services shall be limited to the lowest of the published charges, Statewide Maximum Allowances (SMAs), ~~negotiated rates,~~ or actual cost. ~~if the provider does not contract on a negotiated rate basis. To provide mutually beneficial incentives for efficient fiscal management, providers contracting on a negotiated rate basis shall share equally with the Federal Government that portion of the Federal reimbursement that exceeds actual cost.~~ In no case will payments exceed SMAs.

A. DEFINITIONS

"Published charges" are usual and customary charges prevalent in the public mental health sector that are used to bill the general public, insurers, and other non-Title XIX payors. (42 CFR 447.271 and 405.503 (a))

"Statewide maximum allowances" are upper limit rates, established for each type of service, for a unit of service. Units of service are defined as patient days for residential programs, half-days or full-days for day services, blocks of four hours for crisis stabilization services, and minutes for all other program services.

~~"Negotiated rates" are fixed, prospective rates of reimbursement, subject to the limitations described in the first paragraph above.~~

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in HCFA Publications 15-1.

"Provider" means each legal entity providing Short-Doyle/Medi-Cal services.

TN No. 09-004B

Supersedes

TN No. 93-009 Approval Date _____ Effective Date January 1, 2009

"Legal entity" means each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency.

B. REIMBURSEMENT METHODOLOGY FOR ~~NON-NEGOTIATED RATE~~ PROVIDERS

REIMBURSEMENT LIMITS

The reimbursement methodology for ~~non-NEGOTIATED RATE PROVIDERS~~ Short-Doyle/Medi-Cal services providers, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a NOMINAL CHARGE PROVIDER (as defined below).
2. The provider's allowable cost.
3. The SMAs established as defined in Section D. by the Department of Mental Health (DMH) and approved by the Department of Health Care Services (DHCS).

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each legal entity providing services. For hospital providers, reimbursement is determined separately for inpatient and outpatient services. Reimbursement is based on comparisons of total, aggregated allowable costs after application of SMAs to total, aggregated published charges, by legal entity, computed separately for inpatient and outpatient services but without further distinction between different types of outpatient services.

NOMINAL CHARGE PROVIDER

Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of actual cost or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for outpatient, rehabilitative, case management, and other services is made in accordance with, and by extension from, Medicare inpatient rules at 42 CFR 413.13(f) (2) (iii). For

TN No. 09-004B

Supersedes

TN No. 93-009 Approval Date _____ Effective Date January 1, 2009

Hospital providers, the determination is made separately for inpatient and outpatient services. The determination is based on comparisons of total, aggregated actual costs to total, aggregated published charges, by legal entity, computed separately for inpatient and outpatient services but without further distinction between different types of outpatient services.

~~C. REIMBURSEMENT METHODOLOGY FOR NEGOTIATED RATE PROVIDERS~~

~~REIMBURSEMENT LIMITS~~

~~The reimbursement methodology for NEGOTIATED RATE PROVIDER Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:~~

- ~~1. The provider's published charge to the general public, unless the provider is a NOMINAL CHARGE PROVIDER (as defined below),~~
- ~~2. The provider's negotiated rates, based on historic cost, approved by the State,~~
- ~~3. The SMAs established as defined in Section D. by the DMH and approved by DHS.~~

~~The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each legal entity. The methodology is the same as in Section B except that the Negotiated Rates are construed to be actual costs. If reimbursement to a negotiated rate provider exceeds actual costs in the aggregate, 50 percent of the Federal Financial Participation (FFP) that exceeded actual costs will be returned to the Federal government.~~

~~NOMINAL CHARGE PROVIDER~~

~~Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low income patients are reimbursed the lower of negotiated rates or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for outpatient, rehabilitative, case management, and other services is made in accordance with, and by extension from, Medicare inpatient rules at 42 CFR 413.13(f)(2)(iii).~~

TN No. 09-004B

Supersedes

TN No. 93-009 Approval Date _____ Effective Date January 1, 2009

Attachment 4.19-B

Page 24

~~For hospital providers, the determination is made separately for inpatient and outpatient services. The determination is based on comparisons of total, aggregated actual costs to total, aggregated published charges, by legal entity, computed separately for inpatient~~

~~and outpatient services but without further distinction between different types of outpatient service.~~

C ~~D~~ SMA METHODOLOGY

The SMAs are based on the statewide average cost of each type of service as reported in year-end cost reports for the most recent year for which cost reports have been completed. County administrative and utilization review costs are isolated and not included in the direct treatment payment rates. After eliminating rates in excess of one standard deviation from the mean, the top ten percent of providers with the highest rates are eliminated from the base data to afford cost containment and allow for an audit adjustment factor. The total costs of each type of services are then divided by the total units of service to arrive at a statewide average rate. The adjusted average rates are inflated by a percentage equivalent to the Home Health Agency Market Basket Index for the period between the cost report year and the year in which the rates will be in effect.

The State Fiscal Year 1998-90 cost report data was used to develop base rates. The rates from the base year were adjusted for inflation annually by applying the Home Health Agency Market Basket Index. When the SMAs are re-based, the data will be adjusted to reflect the lower of actual costs or the SMA's in effect of the base year.

The SMAs for crisis stabilization, adult crisis residential treatment, and adult residential treatment are provisional because these are new services not included in the current database. The SMA for crisis stabilization is based on a cost survey of fourteen county programs that provide services for up to 24 hours in an emergency room setting. The SMAs for the two residential programs are based on a cost survey for approximately sixty facilities and include reimbursement only for treatment; room and board costs are excluded. No Federal funds will be used for IMD services. All three provisional rates will be reviewed and rebased for State Fiscal Year 1995-96 based on State Fiscal Year 1993-94 cost report data.

TN No. 09-004B

Supersedes

TN No. 93-009 Approval Date _____ Effective Date January 1, 2009

Attachment 4.19-B
Page 25

The SMA for psychiatric health facilities is also provisional and new for State Fiscal Year 1994-95. The SMA is based on a cost survey of six county programs which provide rehabilitative services in a non-IMD 24-hour environment. Room and board costs are excluded. The provisional SMA will be reviewed and rebased

for State Fiscal Year 1996-97 based on State Fiscal Year 1994-95 cost report data.

D. SHORT-DOYLE/MEDI-CAL REIMBURSEMENT METHODOLOGY, INTERIM PAYMENT, COST REPORT SD/MC RECONCILIATION AND FINAL RECONCILIATION PROCESSES

INTERIM PAYMENTS

Claims for units of service provided under this Section shall be submitted by providers to the county Medi-Cal MHP. Units of service which the county MHP approves shall be reimbursed in full by the county MHPs. The county MHPs shall then submit approved services for the State for reimbursement of Medicaid federal financial participation (FFP) on a fee-for-service (FFS) basis utilizing:

1. Procedure codes established by the state and approved for each provider;
2. Providers approved rates as established through this section for each procedure code.

Units of service approved by the State as eligible for Medi-Cal reimbursement shall be reimbursed by the State as interim payment to the County MHP.

COST REPORTS

The cost report is required to be completed by all legal entities furnishing local community mental health services. The objectives of the Department of Mental Health cost report are to:

1. Compute the cost per unit for each service function;
2. Determine the estimated net Medi-Cal entitlement (FFP) for each legal entity;
3. Identify the sources of funding;
4. Serve as a basis for the local mental health agency's year-end cost settlement, focused reviews and subsequent SD/MC fiscal audit; and
5. Serve as the source for County Mental Health fiscal year-end cost information.

TN No. 09-004B

Supersedes

TN No. 93-009 Approval Date _____ Effective Date January 1, 2009

Attachment 4.19-B
Page 26

SD/MC RECONCILIATION

The SD/MC reconciliation process allows counties to add or reduce Medi-Cal units of service and revenue that have changed subsequent to the cost report submission for each legal entity.

FINAL COST SETTLEMENT PROCESS

After completion of the SD/MC reconciliation, a final settlement of both federal and state fund is calculated and sent to the county and DMH Accounting for payment or collection.

E. ALLOWABLE SERVICES

Allowable outpatient, rehabilitative, case management, and other services and units of service are as follows:

| <u>Service</u> | <u>Units of Service</u> |
|------------------------------------|--------------------------------|
| Day Treatment Intensive | Half-day or Full-Day |
| Day Rehabilitative | Half-day or Full-Day |
| Mental Health Services | Single Minutes |
| Medication Support | Single Minutes |
| Crisis Intervention | Single Minutes |
| Crisis Stabilization | One-Hour Blocks |
| Case Management/Brokerage | Single Minutes |
| Adult Crisis Residential Treatment | Day (Excluding room and board) |
| Adult Residential Treatment | Day (Excluding room and board) |
| Psychiatric Health Facility | Day (Excluding room and board) |

TN No. 09-004B

Supersedes

TN No. 94-022 Approval Date _____ Effective Date January 1, 2009

State/Territory California

| Citation | Condition or Requirement |
|----------|--------------------------|
|----------|--------------------------|

REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL
ACUTE INPATIENT SERVICES

The policy of the State Agency is that reimbursement for Short-Doyle/Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMAs), ~~negotiated rates,~~ or actual cost ~~if the provider does not contract on a negotiated rate basis. To provide mutually beneficial incentives for efficient fiscal management, providers contracting on a negotiated rate basis shall share equally with the Federal Government that portion of the Federal reimbursement that exceeds actual cost.~~ In no case will payments exceed SMAs.

A. DEFINITIONS

"Published charges" are usual and customary charges prevalent in the public mental health sector that are used to bill the general public, insurers, and other non-Title XIX payors. (42 CFR 447.271 and 405.503 (a))

"Statewide maximum allowances" are upper limit rates, established for each type of service, for a unit of service. A unit of service is defined as a patient day for acute hospital inpatient services. Maximum allowances are established, and effective for, each state fiscal year.

~~"Negotiated rates" are fixed, prospective rates of reimbursement, subject to the limitations described in the first paragraph above.~~

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and n HCFA Publication 15-1.

"Provider" means each legal entity providing Short-Doyle/Medi-Cal services.

"Legal entity" means each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department agency.

TN No. 09-004A

Supersedes

TN No.: 93-009 Approval Date: _____ Effective Date: January 1, 2009

B. REIMBURSEMENT METHODOLOGY FOR ~~NON-NEGOTIATED RATE~~ PROVIDERS

REIMBURSEMENT LIMITS

The reimbursement methodology for ~~non-NEGOTIATED RATE PROVIDER~~ Short-Doyle/Medi-Cal services providers, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a NOMINAL CHARGE PROVIDER (as defined below).
2. The provider's allowable cost.
3. The SMAs established as defined in Section D. by the Department of Mental Health (DMH) and approved by the Department of Health Care Services (DHCS)

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each hospital provider.

NOMINAL CHARGE PROVIDER

Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of the actual cost or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for inpatient hospital services is made in accordance with Medicare rules at 42 CFR 413.13 (f) (2) (iii).

~~C. REIMBURSEMENT METHODOLOGY FOR NEGOTIATED RATE PROVIDERS~~

~~REIMBURSEMENT LIMITS~~

~~The reimbursement methodology for NEGOTIATED RATE PROVIDER Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:~~

- ~~1. The provider's published charge to the general public, unless the provider is a NOMINAL CHARGE PROVIDER (as defined below),~~
- ~~2. The provider's negotiated rates, based on historic cost, approved by the State,~~

TN No. 09-004A

Supersedes

TN No. 93-009 Approval Date: _____ Effective Date: January 1, 2009

~~3. The SMAs established as defined in Section D. by the DMH and approved by the DHS.~~

~~The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each hospital provider. If reimbursement to a negotiated rate provider exceeds actual costs in the aggregate, 50 percent of the Federal Financial Participation (FFP) that exceeded actual costs will be returned to the Federal government.~~

~~NOMINAL CHARGE PROVIDER~~

~~Pursuant to Medicare rules at 42 CFR 413.13, public providers and non public providers with a significant portion of low income patients are reimbursed the lower of negotiated rates or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for inpatient hospital services is made in accordance with Medicare rules at 42 CFR 413.13 (f) (2) (iii).~~

C. ~~D.~~ SMA METHODOLOGY

The SMAs are based on the statewide average cost of a hospital inpatient day as reported in year-end cost reports for the most recent year for which cost reports have been completed. County administrative and utilization review costs are isolated and not included in the direct treatment payment rates. After elimination hospitals with rates in excess of one standard deviation from the mean, the top ten percent of providers with the highest rates are eliminated from the base data to afford cost containment and allow for an audit adjustment factor. The total remaining cost of hospital inpatient services are then divided by the total number of patient days to arrive at a statewide average rate. The adjusted average rates are inflated by a percentage equivalent to the medical component of the national Consumer Price Index for the period between the cost report year and the year in which the rates will be in effect.

The State Fiscal Year 1989-90 cost report data will be used to develop base rates. The rates from the base year will be adjusted for inflation annually by applying the medical component of the national Consumer Price Index. When the SMAs are re-based in no more than three years, the cost report data will be adjusted to reflect the lower of actual costs or the SMA's in effect for the base year.

TN No. 09-004A

Supersedes

TN No. 93-009 Approval Date: _____ Effective Date: January 1, 2009