CLASSIFICATION OF FIXED AND VARIABLE COSTS

FIXED COSTS	VARIABLE COSTS
SALARIES AND WAGES	SALARIES AND WAGES
Management and supervision	Registered nurses
Technician and specialist	Licensed vocational nurses
Clerical and other administrative	Aides and orderlies
Physicians	Environmental and food Services
Nonphysician medical practitioners	Other salaries and wages
EMPLOYEE BENEFITS-Distributed proportionately according to salaries and wages	EMPLOYEE BENEFITS-Distributed proportionately according to salaries and wages
FICA	FICA
Unemployment insurance	Unemployment insurance
Vacation, holiday, and sick leave	Vacation, holiday, and sick leave
Group insurance	Group insurance
Pension and retirement	Pension and retirement
Workers' compensation	Workers' compensation
Other employee benefits	Other employee benefits
OTHER DIRECT EXPENSES	PROFESSIONAL FEES
Insurance	Medical
Other direct expenses	Consulting and management
	Legal
	Audits
	Other professional fees
	SUPPLIES
	Food
	Surgical supplies
	Pharmaceuticals
	Medical care materials
	Minor equipment
	Nonmedical supplies
	PURCHASED SERVICES
	Medical
	Repairs and maintenance
	Management services
	Other purchased services

3) A provider may submit additional data on the classification of fixed and variable costs for review by the Department with the AAR. If these alternative classifications and/or data are accepted by the Department, the provider shall continue to:

   (a) Utilize these accepted classifications of fixed and variable costs in all FPEs.

   (b) Submit to the Department, along with their filed cost report, any required data on fixed and variable costs necessary to do the alternative calculations for all subsequent FPEs. If the provider fails to supply the data with the cost report, they shall have their interim payments reduced by 20 percent. If the data has not still been supplied 60 days after the 20 percent reduction in interim payments begins, the provider shall have their interim payments reduced by 100 percent until the data are supplied. The provider shall be given 30 days advance notice to supply the required data before any reductions in interim payments are applied under this part of the Plan.

4) All providers must supply the data items for each FPE necessary to do the PIRL calculations. The data must be supplied as part of each provider's Medi-Cal cost report.

K. Summary of ARPDL formula for provider with full settlement and full prior fiscal periods:

(1) ARPDL = MCDIS *
(2) (((RENTS + LIC + PTAX + DEP + LEAS + INT + UTL + MPI) / THD) +
(3) (((PMIRL - (PMCDIS * (TPTCPP / PTHD))) / PMCDIS) *
(4) (((((PX1 * (MPFP / (GOEPP - TPTCPP))) +
(5) (PX2 * (OPFP / (GOEPP - TPTCPP))) +
(6) (PX3 * (FOODP / (GOEPP - TPTCPP))) +
(7) (PX4 * (DRUGP / (GOEPP - TPTCPP))) +
(8) $\left(\left(\sum_{k=1}^{6} (PYH_k * CYHR_k) / \sum_{k=1}^{6} (PYH_k * PYHR_k)\right) *\right.$
(9) (SWP / (GOEPP - TPTCPP))) +
(10) (((PYHT * CYBR) / PYB) *
(11) (PYB / (GOEPP - TPTCPP))) +
(12) (PXO * (OTCP / (GOEPP - TPTCPP)))) *
(13) $((DIS_p + (VC * (DIS_f - DIS_p)))/DIS_f)) *$
(14) $\left(\left(\left(\sum_{i=1}^{n} DRGC_i\right) / MCDIS\right) / \left(\left(\sum_{j=1}^{n} DRGP_j\right) / MCDISP\right)\right) +$
(15) (STA + PI + SI))))

Where:

ARPDL = All-Inclusive Rate Per Discharge Limitation.
MCDIS = Medi-Cal discharges in the settlement fiscal period.
RENTS = Rental costs for the settlement fiscal period.
LIC = License fees for the settlement fiscal period.
PTAX = Property Tax expenses for the settlement fiscal period.
DEP = Total allowable Depreciation expenses for the settlement fiscal period.
LEAS = Lease expenses for the settlement fiscal period.
INT = Allowable Interest expense for the settlement fiscal period.
UTL = Allowable utility expenses for the settlement fiscal period.
MPI = Total Malpractice Insurance costs for the settlement fiscal period.
THD = Total hospital discharges for the settlement fiscal period.
PMIRL = MIRL (Lowest of rate, costs and charges) for the prior fiscal period.
PMCDIS = Medi-Cal discharges in the prior fiscal period.
TPTCPP = Total allowable pass-through costs for the prior fiscal period.
PTHD = Total hospital discharges for the prior fiscal period.
PX1 = Price index for medical professional fees.
MPFP = Allowable Medical Professional Fees for the prior fiscal period.
GOEPP = Gross Operating Expenses (GOE) for the prior fiscal period.
PX2 = Price index for Other Professional Fees.
ODFP = Allowable Other Professional Fees for the prior fiscal period.
PX3 = Price Index for Food costs.
FOODP = Allowable food costs for the prior fiscal period.
PX4 = Price Index for Drug costs.
DRUGP = Allowable costs for Drugs for the prior fiscal period.
PYH_k = Prior fiscal period hours paid for employee classification k.
$CYHR_k$ = Settlement Fiscal Period Hourly Wage rate for employee classification k.
$PYHR_k$ = Prior fiscal period Hourly Wage Rate for employee classification k.
SWP = Allowable costs for salaries and wages for the prior fiscal period.
PYHT = Prior fiscal period paid hours.
CYBR = Settlement fiscal period hourly benefits rate.
PYB = Prior fiscal period benefits.
PXO = Price Index for Other Costs.
OTCP = Other allowable costs for the prior fiscal period.
DIS_p = Total hospital discharges for the prior fiscal period.
VC = Variable cost proportion for the prior fiscal period.
DIS_f = Total hospital discharges for the settlement fiscal period.
$DRGC_i$ = DRG weight for patient i in the settlement fiscal period.
n = Number of DRG weights in the settlement fiscal period.
$DRGP_j$ = DRG weight for patient j in the prior fiscal period.
m = Number of DRG weights in the prior fiscal period.
MCDISP = Medi-Cal discharges in the prior fiscal period.

STA = Adjustment factor for Scientific and Technological Advancement.
PI = Adjustment factor for Productivity Improvement.
SI = Adjustment factor for Service Intensity.

Lines 2 through 15 are the ARPD = All-Inclusive Rate Per Discharge.
Line 2 is the PASPD = Pass-through cost per discharge.
Line 3 is the PNPARPD = Prior fiscal period Non-pass through MIRL Reimbursement Rate Per Discharge.
Lines 4 through 12 are the IPI = Input Price Index.
Lines 4 through 13 are the AIPI - Adjusted Input Price Index.
Lines 4 through 15 are the HCI = Hospital Cost Index.
Line 8 is the SWI = Salary and Wage Index.
Line 10 is the EBI = Employee Benefits Index.
Line 13 is the VAF = Volume Adjustment Factor.
Line 14 is the CMAF = Case Mix Adjustment Factor.
Line 15 is the SIPTF = Allowance for Service Intensity, Productivity, and Scientific and Technological Advancement Factor.

VI. ADMINISTRATIVE ADJUSTMENT PROCESS

A. A provider may request an AA to the ARPDL or PGRPDL established for that provider if the provider's cost based allowable reimbursement for the settlement fiscal period as defined by the lower of Section II A. 1) and 2) of this Plan, exceeds or are expected to exceed the PIRL by over $100. Expected to exceed only refers to the settlement period being issued and not any future settlement fiscal periods. The burden shall be on the provider to estimate, using the PIRL settlement information provided by the Department and any other information they may have, if they will expect to exceed the PIRL by over $100.

B. Items that are not subject to an AA or appeal include the following:

1) The use of Medicare standards and principles of reimbursement.

2) The reimbursement amounts determined in Section II A. 1) and A. 2) of this Plan.

3) The method for determining the IPI.

4) The use of all-inclusive reimbursement rates.

5) The use of a volume adjustment formula.

6) Disproportionate share payments (these are not reduced by application of the PIRL).

7) Data reported on the cost report which has been audited or reviewed by the Department or considered true and correct pursuant to W&I Code Section 14170. Data that was incorrectly transferred from the providers Medi-Cal cost or audit report and used to calculate the MIRL is subject to appeal.

8) The methodology used to calculate the interim rate.

9) Any prior fiscal period issues, including the base period.

10) Higher costs due to low occupancy.

11) Items not reimbursed as part of the Medi-Cal cost report process as determined in Section II A. 1) and A. 2) of this Plan.

12) Increased costs. Only the cause for the increased costs may be appealable, and then only if it is otherwise an appealable item.

13) Any issue raised in a previous formal appeal for which a decision was made by the Department for the same provider. The only exception is to incorporate into the settlement fiscal period PIRL the prior decision in the same manner as it was previously decided by the Department. These only include decisions made for FPEs affected by Parts I through XIII of this Plan. This does not include issues withdrawn by the provider and thus not determined on their merits in the formal decision.

14) Increases in average length of stay.

15) Changes in the Cost-Based Reimbursement System as determined under Section II A. 1) and A. 2) of this Plan.

16) Increased costs incurred by entering into a contract which did not contain reasonable cost increase limitations.

17) Increases due to increased costs or charges of a related party.

18) Any issues involving labor cost increases except for those allowed in Section VII B. of this Plan.

19) New services.

C. Issues involving the following MIRL (or ARPDL but not PGRPDL) items may be resolved through an AA under the procedures in Section VII of this Plan.

1) Changes in Medi-Cal case mix and outliers.

2) Inappropriate calculation of fixed and variable costs.

3) An error in the calculations.

4) Determination of whether or not a provider is exempt from the ARPDL.

5) Extraordinary and unusual events.

6) Labor costs as allowed under Section VII B. of this Plan.

7) Other causes of cost increases for costs which were economically and efficiently incurred for the necessary care of Medi-Cal inpatients, that are an increase on a per-discharge basis over the prior fiscal period and are not listed under B. as not being subject to an AAR.

8) The interim rate as it may be affected by changes resulting from items appealed under 1) through 7) above.

D. If a provider's cost based reimbursement is the lower of Section II A. 1) and A. 2) of this Plan and exceeds both the ARPDL and the PGRPDL, the providers' AAR and any subsequent appeal of the AA, must address both limitations in order to obtain relief for both limitations. If only the ARPDL is appealed, no further appeal rights will exist for the PGRPDL at any later date, except for an AAR on a tentative PIRL settlement that is issued later as a final PIRL settlement.

E. The procedures for requesting an AA of an ARPDL shall be as follows:

1) A request for an AA of the ARPDL or PGRPDL, which the

Department deems acceptable, shall be submitted within 90 days after notification of that limitation. These AARs must be postmarked or hand delivered on or before the 90th day after the postmark on the settlement notification letter. No extensions shall be granted. If a settlement letter from the Department contains settlements for more than one fiscal period, 120 days shall be allowed to file the AAR.

2) The AAR shall be submitted in writing to the Department and shall specifically and clearly identify each issue, the total dollar amount involved for each issue and the dollar amount of overlap among each issue. If the Department determines that additional data are needed, the provider shall have 60 days after written notification of the Department's request to supply it to the Department. No extension shall be granted.

3) The AAR need not be formal, but it shall be in writing and specific as to each issue in dispute, setting forth the provider's specific contentions as to those issues and the estimated amount each issue involves. If the Department determines that the request for any issue fails to state the specific grounds upon which objection to the specific issue is based, including the estimated dollar amount involved, the provider shall be notified that it does not comply with the requirements of this regulation and the issue cannot be accepted. If an issue is not accepted on this basis, the provider may not submit this issue as a formal appeal.

4) All AARs must be signed by an employee of the provider authorized by the provider to do so or by an authorized representative.

   (a) If the AAR is signed by an authorized representative, a signed statement of such authorization for each fiscal period must accompany the AAR signed by an appropriate employee of the provider.

   (b) Each AAR must have a declaration attesting to the validity of all statements contained in the AAR. The declaration shall be signed by an appropriate employee of the provider or an authorized representative.

5) For each issue other than those covered by one of the specific formulas in this Plan the provider must demonstrate either (a), (b) or all parts of (c) below:
   (a) Data that was incorrectly transferred as specified in Section VI B. 7) of this Plan.

   (b) An error was made in the rate calculation.

   (c) All costs for which additional reimbursement are being requested were:

      1. economically and efficiently provided for the necessary care of Medi-Cal inpatients.

      2. not already included in the ARPDL and/or PGRPDL, whichever limitation(s) is being appealed.

      3. not overlap with any other AAR issue, or if there were, all such overlap must be used to reduce any additional reimbursement which would otherwise have been granted.

6) The request shall contain all the appropriate data to allow the Department to determine if relief is needed and to do the relief calculation.

   (a) This may include, but is not limited to:

      1. All internal/external reports concerning each issue;

      2. All material presented to the hospitals' Governing Board concerning this issue;

      3. Medical records for Medi-Cal patients;

      4. Bank statements and canceled checks;

      5. All financial statements;

      6. Copies of contracts.

      7. Copies of proposed and/or actual budgets.

      8. The provider's suggested calculation for relief except for each issue specifically listed under Section VII below, the formula in this Plan must be used.

(b) All data submitted must be accompanied by one or more statements attesting that the data are true and correct signed by an individual with knowledge of the submitted data. More than one statement may be required if more than one data source is utilized.

(c) All data submitted may be audited by the Department.

7) One-time relief may be granted for extraordinary and unusual events.

(a) The criteria for one-time relief is any item which occurred in one fiscal period and is not normally expected to apply to all future fiscal periods and therefore the ARPDL is not adjusted each future fiscal period for this issue.

(b) Formula relief shall only be granted for issues which are expected to carry on to every future fiscal period.

(c) Any relief granted for allowable increases in employee hours per discharge shall be one-time relief for the first two fiscal periods and then formula relief during the third fiscal period.

8) The following steps are required by the Department for calculating relief:

(a) The provider shall clearly identify each issue and the estimated dollar amount of relief for each issue.

(b) The provider shall identify the specific cause of the increased costs.

(c) The provider shall calculate what reimbursement is already included in the ARPDL due to this issue (such as pass-throughs) and/or overlap from other AAR issues.

(d) The Department shall review the providers' figures on (a) and make any necessary corrections.

(e) The Department shall determine whether to grant one-time or formula relief or no relief.

9) If data or other items requested by the Department for evaluation of an AAR are not supplied within 60 days, the Department shall suspend further consideration of this issue. After written notification if the requested data are not supplied within 120 days, the Department shall deem the AAR rejected for all issues for which the Department requested data or other items, and the provider shall be precluded from raising the issues in a formal appeal.

10) The provider shall be notified of the Department's decision in writing within 90 days of receipt of the provider's written request for an AA or within 60 days of receipt of any additional documentation or clarification which was required by the Department, whichever is later. The request for an AA shall be deemed denied if no decision is issued within these time frames.

11) A change in cost based reimbursable costs as defined in Section II A. 1) and A. 2) of this Plan whether or not as a result of an audit appeals process, shall result in a redetermination of the PIRL, and shall not give rise to any additional appeal rights.

VII. SPECIFIC ADMINISTRATIVE ADJUSTMENT ISSUES

A. AAs for year-to-year changes in case mix and/or outliers under the ARPD (not the PGRPD) shall be resolved in the following manner:

1) The case mix adjustment factor (CMAF) shall be calculated using the following steps:

(a) the provider shall supply a listing for every Medi-Cal discharge that occurred during both the settlement fiscal period and the prior fiscal period, sorted in admission date order, and shall include as a minimum:

1. The patient's last name and first initial.

2. Medi-Cal I.D. Number.

3. The admission date.

4. The discharge date.

5. The principal diagnosis code.

6. The total amount of billed charges.

7. The DRG number.

8. The DRG weight. The same set of DRG groups and weights must be used for both settlement fiscal period and prior fiscal period data. If charges for a newborn were billed together with its mother, the newborns and the mother must be listed separately on this listing, each with their own DRG and weight.

9. The sum of the cost weights and the number of Medi-Cal DRG discharges on the list. The number of Medi-Cal DRG discharges on the list must equal or exceed the number of audited Medi-Cal discharges. The listing must include all Medi-Cal patients, which includes newborns that are not counted as Medi-Cal discharges.

(b) The sum of the cost weights for each FPE shall be divided by their respective number of Medi-Cal discharges (not the number of patients in the listing) to obtain the average DRG weight for each fiscal period.

(c) The settlement fiscal period average DRG weight shall be divided by the prior fiscal period average DRG weight to obtain the CMAF.

(d) DRG cost weights used in this Section may be any set used by Medicare during any part of either the settlement or prior fiscal period. The Department may also publish a set of Medi-Cal or California specific DRG cost weights, day outlier cutoffs and classifications as an option for the providers to use.

(e) Once a CMA is granted, each subsequent fiscal period ARPDL shall include a CMA (even if the adjustment is negative) and the provider shall supply all required data necessary to do the CMA calculation to the Department within 9 months after the end of each subsequent FPE. Failure to do so will result in a 20 percent reduction to the provider's current interim payments. If the data

is not received within 12 months of the end of the FPE, the interim payment reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent. If a provider does not supply the data prior to the issuance of the final settlement, the CMAF shall be calculated so as to remove the affect of all previous CMAFs by compounding the previous CMAFs and applying the result to decrease the settlement fiscal periods ARPD. The provider shall not be eligible for a CMAF for any fiscal period. However, if the tentative PIRL settlement is issued within 9 months of the end of the FPE and the case mix data has not yet been supplied, then a CMAF of 1.0 shall be used for the tentative PIRL settlement only.

The provider shall be given 30 days advance notice prior to applying any reductions in interim payments under this part of the plan.

(f) For noncontract hospitals, the DRG weights shall be modified by one of the following two methods:

1. All DRG weights for all patients transferred to other acute care hospitals after being stabilized will be multiplied by 0.4 (a 60 percent reduction).

2. All DRG weights for patients transferred to other acute care hospitals after being stabilized shall be adjusted as follows:

   a. For each patient transferred list the charges from the hospital they were transferred to.

   b. Divide each patient's charges at the provider's hospital by the patient's total charges (which includes charges from both the hospital they were transferred to and the hospital they were transferred from).

   c. Multiply the result of b. for each patient by their DRG weight to obtain a new weight to use in the CMAF calculation.

3. The provider shall choose which option it will use. If the provider fails to specify an option in their AAR, the Department shall use option 1 above.

4. Outlier calculations for these providers shall be adjusted by using the costs and days for the patients while they are at both providers, and using the same allocation formula in 1-3 above.

2) Additional reimbursement shall be granted to approximate a hospital's increases, on a per discharge basis, in the marginal cost of care beyond specified thresholds that are not already reimbursed for in the ARPDL, including the CMAF. AARs for additional reimbursement due to outliers (both cost and day outliers) shall be determined as follows:

(a) If the provider has received a CMAF for the settlement fiscal period, then the outlier relief shall be calculated by:

1. the hospital shall also include on the listing required under A. 1) above the following additional items:

a. The length of stay for each patient.

b. The outlier cutoffs, in terms of both days and costs, as determined in accordance with Medicare prospective payment rules and regulations for the applicable time period of each individual patient. However, wherever the Medicare formula uses a cost-to-charge ratio, the hospital specific cost-to-charge ratio shall be used. If the provider elects to use an alternative set of DRG weights published by the Department to calculate their CMAF, then the corresponding set of alternative outlier cutoffs must be used for each patient.

c. If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL

divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for each patient.

d. For patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows:

(1) The outlier cost cutoff shall be the greater of:

a) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period.

b) 1.5 multiplied by the ARPD multiplied by the DRG weight for the patient.

(2) The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient.

(3) The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80.

e. The cost to charge ratio as determined from the cost report for both the settlement and prior fiscal period.

(1) If a patient qualifies as both a day and cost outlier, they shall be treated only as a day outlier.

(2) Sum the amounts calculated in 2) (a)1. c. and d. above and divide by the respective number of Medi-Cal discharges for each FPE.

(3) Relief shall be calculated by subtracting the prior fiscal period result of (2) from the settlement fiscal period result of (2).

(4) Once an outlier adjustment, in conjunction with a CMA, has been granted, it shall be included in all subsequent settlements even if it is a negative adjustment. Data necessary to do the outlier calculation shall be submitted each FPE within 9 months of the end of the FPE or current interim payments shall be reduced by 20 percent. If the data is not received within 12 months of the end of the FPE, the interim payments reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent.

The provider shall be given 30 days advance notice prior to applying any reduction on interim payments under this part of the Plan.

(b) If a provider has not elected a CMA, then relief for outliers shall be calculated as follows:

1. Providers shall provide lists containing the number of patients for every length of stay for both the settlement fiscal period and the prior fiscal period. For newborns not counted as separate Medi-Cal discharges, their days shall be added to their mother's.

2. The settlement fiscal period and prior fiscal period mean lengths of stay for all Medi-Cal patients shall be calculated by dividing total Medi-Cal patient days (including nursery days) by Medi-Cal discharges for each respective fiscal period.

3. Calculate the standard deviation of the length of stay for all patients in the prior fiscal period.

4. Compute 1.94 standard deviations of the mean length of stay in the prior fiscal period and add the result to the mean length of stay in the prior fiscal period.

5. Round the result in 4. above down to the next whole number to establish the outlier threshold to be used for both prior and

settlement fiscal periods.

6. List the patients who exceeded the result of 5. above in either the settlement or prior fiscal period. Include in the list the patient's name, admission date, discharge date, length of stay and charges.

7. Calculate the amount of day outlier payments by:

a. Subtracting the result of 5. above from the length of stay of each patient whose stay exceeded the outlier threshold each FPE.

b. Sum the total days calculated in a. above for each FPE.

c. Divide the number from b. above by the number of Medi-Cal discharges in each respective FPE.

d. Subtract the prior fiscal period result of c. above from the settlement fiscal period result of c..

e. Multiply the result of d. above by the number of settlement fiscal period Medi-Cal discharges.

f. Calculate a per diem rate by dividing the settlement fiscal period MIRL by the total number of patient days (including newborn days).

g. Relief is calculated by multiplying the result of 7. e. above by the result of 7. f. above.

8. For patients who do not qualify as a day outlier, additional relief shall be provided as a cost outlier as follows:

a. For both the prior fiscal period and settlement fiscal period, the provider shall provide a listing of the number of patients by charge category (in either $100 or $200 increments) in order to calculate the mean and standard deviation.

b. Calculate the mean charge per discharge and standard deviation for both FPEs.

c. Convert the means and standard deviations to costs per discharge, by using the allowable cost to charge ratio from the cost report for each respective FPE.

d. Calculate the increase in the cost per discharge by dividing the settlement fiscal period mean cost per discharge by the prior fiscal period mean cost per discharge.

e. Calculate the prior fiscal period cost outlier cutoff by adding 1.94 standard deviations to the mean cost per discharge.

f. The prior fiscal period charge cutoff shall be the result of step e. above divided by the prior fiscal period allowable cost to charge ratio from the cost report.

g. Calculate the settlement fiscal period charge outlier cutoff by multiplying the results of d. above by the result of f..

h. For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above:
   (1) Last name and first initial.

   (2) Admission date.

   (3) Length of stay.

   (4) Charges.

   (5) Amount of charges over the threshold.

   (6) Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.

i. Sum the items under (6) above for both the prior and settlement fiscal periods (separately).

j. Adjust prior fiscal period costs to settlement fiscal period costs by multiplying the prior fiscal period item i. above result times the result of d. above.

k. Divide the results of prior fiscal period j. above and settlement fiscal period j. above by the respective number of Medi-Cal discharges each FPE.

l. Subtract the prior fiscal period result of k. above from the settlement fiscal period result of k. above.

m. Multiply the result of l. above (minimum of zero) by the settlement fiscal period number of Medi-Cal discharges.

n. Add the result of m. above to the MIRL and divide by the settlement fiscal period net cost of covered services.

o. Multiply the lesser of the result of d. above or 1.0 by the result of n. above to calculate the additional amount of relief for cost outliers who do not qualify as day outliers. This cannot exceed the amount of the MIRL liability.

B. AAs for changes in labor costs shall be resolved in the following manner:

1) Relief from the SWI and EBI can be granted if, and only if, the basis is due to labor/benefit cost increases per discharge resulting from either the new adherence to existing requirements imposed by government regulations, rules, and/or statutes or the adherence to new requirements imposed by government regulations, rules, and/or statutes. This includes new rules and new adherence to rules imposed by the Joint Commission on Accreditation of Health Organizations. The adherence to the regulations, rules, and/or statutes must be necessary to legally render the provided services to Medi-Cal recipients.

2) The Department will be authorized to grant relief if the provider meets the criteria for relief. Any relief granted shall be based upon an analysis of labor costs both prior and subsequent to the effective date of the

adherence to the requirements. Any request for relief will require the following:

(a) A summation of the governmental requirements necessitating the increase in labor costs;

(b) Additional hours and staff required to adhere to the governmental requirements. The request will specify:

1. The exact title(s) of the added staff;

2. The appropriate employee cost category; and

3. The number of hours and hourly rates for each added or deleted staff member.

(c) Source of the additional support, e.g., new hire or transferred from another employee classification; and

(d) The appropriate pages of the Medi-Cal cost report reflecting the additional costs associated with the increased hours.

3) A separate request shall be rendered for each affected cost center. The cost centers for appeal purposes shall be the exact same cost centers as disclosed in the provider's Medi-Cal cost report as audited by the Department. Relief may be granted only for those cost centers that incurred the expenses as the result of governmental requirements.

4) The Department shall evaluate the submitted data to determine any changes in the following areas for each effected cost center:

(a) Labor hours per discharge;

(b) Labor costs per discharge;

(c) Changes made in other employee classifications that resulted in labor cost increases or decreases.

5) The unit measure of change shall be the ARPD. Any relief granted shall be on a per discharge basis by adjusting the ARPD to incorporate the increased, if any, labor costs per discharge which were not reimbursed in the ARPD and which do not overlap with any

other issues. Any adjustments necessitated by the application of relief shall impact the base rate per discharge and will be carried forward into future settlements.

6) The only basis for relief under Section VII. of this Plan shall be:

(a) Increased employee hours per discharge; or

(b) The requirement to employ more expensive labor, e.g., replace Aides with Registered Nurses.

7) Requests for relief on the basis of increased patient acuity will be deferred to Section VII. A. of this Plan. Patient acuity or service intensity shall not be entertained under Section VII. B. of this Plan.

8) Relief sought on the basis of labor disputes shall not be granted. Labor disputes are inclusive of, but not limited to, strikes, arbitration, and/or labor issues where employees in an organized, collective, or unified movement refrained from physically reporting to perform their routine duties or physically reported but refrained from performing their routine duties.

9) Relief shall not be granted under Section VII. B. of this Plan as the result of circumstances created when the provider switched to or from nursing services instead of salaried personnel.

C. The following steps will be used for calculating relief, if any, for any ARPDL issues not otherwise specified in this regulation:

1) The provider shall clearly identify the issue and estimated dollar amount of relief.

2) The provider shall determine what is the specific underlying cause of the increased costs. If the underlying cause of the increased costs is not clearly stated, the AAR shall not be accepted by the Department.

3) The provider shall calculate what reimbursement, if any, is already included in the ARPDL due to this issue (such as pass-throughs or case mix covering a new service) and shall also calculate any overlap between this and other AA issues.

4) The Department shall review and correct if necessary, the provider's calculations in steps 1) through 3) above.

5) The Department shall subtract any overlap with other issues from the amount determined in steps 1) through 3) above.

6) The Department shall determine if relief is "one-time" or "formula".

VIII. AA FORMAL APPEALS PROCESS

A. A provider may appeal the Department's decision on the AAR for a final PIRL settlement only. There shall be no appeal on an AAR for a tentative PIRL settlement. The appeal shall be filed and conducted in accordance with the applicable procedural requirements of the provisions of the Plan, except as modified by Section VIII., including the following:

1) The appeal shall be submitted within 30 days after notification of the Department's decision on the AAR,

2) The provider shall present its issues and evidence first at the hearing, as they shall have the burden of going forward.

3) The provider has the burden of proof of demonstrating by a preponderance of the evidence, that the provider's position regarding disputed issues is correct.

4) In order to demonstrate that it is entitled to relief from the PIRL and that the AA decision should be overturned, the provider has the burden of demonstrating by a preponderance of the evidence that the Department's AA decision is inconsistent with the applicable regulatory provisions and that the provider's alternative is consistent with the applicable regulatory provisions.

5) If the Department's AA decision is proved, by a preponderance of evidence, inconsistent with the applicable regulatory provisions, and the provider has not proved by a preponderance of the evidence that its position is consistent with the applicable regulatory provisions, then the Administrative Law Judge (ALJ) may fashion whatever relief is necessary to obtain consistency with the applicable regulatory provisions.

6) Items that are not subject to an AA as specified in Section VII. of this Plan, shall not be subject to appeal.

7) The provider shall be paid at the PIRL initially determined by the Department pending determination of a formal appeal.

8) Any underpayments, identified in the appeal decision, shall be repaid to the provider, together with interest computed at the legal rate of interest beginning the later of the date the payment is received by the Department or the date the appeal is formally accepted by the Department.

9) The evidence to be submitted by the provider at a formal appeal hearing that was not provided to the Department nor specifically and individually identified as available to the Department, during the AA process excluding oral testimony, must be submitted to the Department 30 days before the scheduled date of the hearing. The only exception, is when a hearing is scheduled within 45 days from the date notice is given. In this latter case, evidence must be submitted 15 days before the scheduled date of the hearing. Failure to submit this information within the specified time frames shall result in its exclusion from the formal appeal hearing and record.

10) Recalculation of the PIRL due to an appeal decision shall not give rise to any further appeal rights.

11) If results of an audit appeal of the cost report or any prior fiscal period PIRL, AA or appeal, change data used in the settlement fiscal period PIRL, the PIRL shall be recalculated. The recalculation shall not give rise to further appeal rights.

12) If an issue in an AAR is not accepted pursuant to Section VI. E. 2) and 3), the ALJ may only consider the evidence that was presented in the AAR and not any additional information or testimony. If the ALJ determines that the issue should have been accepted, the issue shall be remanded for a response to the merits.

13) Only those issues that were clearly identified in a timely filed AAR, including an estimated dollar amount for each issue may be accepted as issues on a formal appeal.

IX. PEER GROUPING

A. Hospital reimbursement shall, unless exempted from or modified by the provisions of this Part, be payable at no more than the 60th percentile aligned ARPD of the peer group to which the hospital is assigned by the Department. This limit is the Peer Group Rate Per Discharge Limitation (PGRPDL). The peer groups shall be based on a classification of hospitals as determined in the 1991 Hospital Peer Grouping Report (Appendix C) published by the Department, that combines individual hospitals in a unit on the basis of similar or common characteristics. The following peer group classifications will be used:

1) University Teaching Hospitals.

2) Major (non-university) Teaching Hospitals.

3) Large Teaching Emphasis Hospitals.

4) Medium/small Teaching Emphasis Hospitals.

5) Extremely Large Sized Hospital.

6) Large Sized Hospitals.

7) Moderately Sized Hospitals.

8) Medium Sized Hospitals.

9) Moderately Small Sized Hospitals.

10) Very Small Sized Hospitals.

11) Acute Psychiatric Hospitals.

12) Alcohol-Drug Rehabilitation Hospitals

13) Combination Psychiatric/Alcohol/Drug Rehabilitation Hospitals.

14) Psychiatric Health Facilities.

15) Psychiatric Teaching Hospitals.

16) Psychiatric Children's Hospitals.

17) Moderate Alcohol-Drug Rehabilitation Emphasis Hospitals.

18) Moderate Psychiatric Emphasis Hospitals.

19) State Hospital-Veterans Home.

20) State Hospital-Mental Health.

21) State Hospital-Developmental Services

22) Children's Hospitals.

23) Crippled Children's Hospitals.

24) Rehabilitation Hospitals.

25) Large Rehabilitation Emphasis Hospitals.

26) Respiratory Specialty Hospitals.

27) Student Health Centers.

28) Charitable Research Hospitals.

29) Rural Hospitals.

30) Specialty Teaching Hospitals.

31) Prepaid Health Plan-Psychiatric/Alcohol-Drug Rehabilitation Hospitals.

32) Prepaid health Plan-Teaching Emphasis.

33) Eye Hospitals.

34) Women Hospitals.

35) Dental/Outpatient Hospitals.

B. The Department may review and change the number and definitions of peer groups and the peer group placement of individual providers.

1) Providers shall be notified of all such reviews and resultant changes to the peer groups.

2) For purposes of peer group placement, license beds shall be average licensed beds excluding any beds in suspense in accordance with Section 1271.1 of the Health and Safety Code.

3) All peer group assignments will be for all FPEs between July 1st and June 30th for each fiscal year.

C. Providers exempted from application of the PGRPDL shall consist of new hospitals, rural hospitals, sole community hospitals, children's hospitals, crippled children's hospitals, charitable research hospitals, primary health service hospitals and hospitals in peer groups with less than five Medi-Cal providers.

D. Providers with less than 15 Medi-Cal discharges in any FPE that covers over 360 days, shall be exempt from the PGRPDL for that FPE.

E. The peer group 60th percentile ARPD for each July 1-June 30 FPE shall be calculated by:

1) Obtaining the ARPD for each provider for the FPE during the state's fiscal period (or use the latest available if one is not yet available for the selected time period).

2) Using actual or estimated rates of inflation, align the ARPD for each hospital to a July 1 to June 30 FPE.

3) Locating the 60th percentile, by multiplying 0.6 times one more than the number of ARPDs in the peer group.

4) Starting from the bottom of a list of ARPDs, ordered from the lowest ARPD at the bottom, up to the highest ARPD at the top, count up the number of ARPDs using the result of E. 3) above.

5) Interpolate if necessary.

F. The 60th percentile ARPD shall be updated quarterly.

G. Once a final PIRL settlement is issued for a provider, the 60th percentile ARPD established in that Providers FPE shall not change, even though the final PIRL settlement may be reissued as a "recalculated final PIRL settlement" as a result of any appeal as well as other reasons for recalculation.

X. PEER GROUP ADMINISTRATIVE ADJUSTMENTS

A. A provider may request an AA of the reimbursement limits specified in this Section of the Plan and their peer group placement at the time of tentative and final PIRL settlement.

1) The request shall be made within 90 days after notification of the reimbursement limits and shall be made in accordance with the procedures specified in Section VI. of this Plan.

2) The burden of proof shall be on the provider to prove that the additional reimbursement sought meets all of the requirements under Section VI. and that except where a specific formula in Section XI. exists, the provider's cost per discharge of the item being appealed, exceeds the 60th percentile cost per discharge of the item being appealed.

3) In addition to the items listed under Section VI. B. of this Plan, the following items shall not be subject to an AA of the PGRPDL:

(a) The use of hospital peer groups.

(b) The use of 60th percentiles and the methods used to compute them.

(c) Changes in case mix.

(d) Costs associated with strikes other labor stoppages or slow downs.

(e) The addition of new services.

(f) Costs due to low occupancy.

(g) Difference in the type, nature, or scope of items or services available whether or not provided, between the provider and other providers in its peer group since differences in the actual services needed to be rendered are accounted for in the CMA as specified in Section XI. of this Plan.

(h) Any other issue that is not a difference between the provider and other providers in their peer group.

4) A provider may appeal the Department's decision on the AA for final PIRL settlements only. The appeal shall be in accordance with Section VIII. of this Plan.

XI. PEER GROUP SPECIFIC ADMINISTRATIVE ADJUSTMENT ISSUE

A. Differences in case mix (including outliers) between the provider and other providers in its peer group shall be determined for the PGRPDL using the following formula, but subject to reduction for overlapping issues as specified in D. below:

MARD=PGL * CMA

Where: MARD=Maximum Allowable Rate Per Discharge under the PGRPDL.

CMA=Case mix adjustment factor, which is the providers case mix index divided by the peer group 60th percentile case mix index.

PGL=Peer grouping reimbursement limit per discharge (60th percentile ARPD for the peer group if no adjustments have been made).

1) Case mix indexes shall be based on DRGs and shall be computed using OSHPD patient discharge data for providers. Providers with an ARPD CMAF shall use data they are required to supply for the ARPD CMAF. However, the set of DRG weights used must be consistent for all providers in the peer group and shall be determined by the Department for each FPE.

2) Providers shall be allowed to submit more accurate diagnosis and disposition data used to calculate the DRG case mix index. Any such patient discharge data must be submitted with the AAR. The data cannot be used until it is verified by the Department. The Department shall not accept data that it determines may not accurately reflect the provider's Medi-Cal patients.

3) If OSHPD patient discharge data does not correspond with all provider's FPE the closest FPE shall be used. Indices will be developed for a calendar year and for a July 1 through June 30 FPE. The period which most closely corresponds to the providers' FPE shall be used. Calendar year data shall be used for FPEs from October 1 through March 31 inclusive. July 1 through June 30 fiscal period data shall be used for all other FPEs.

4) CMAs may be applied to any provider with a case mix index greater than the 60th percentile case mix index of its peer group.

5) In addition to case mix relief, a provider shall be granted relief for outliers if the provider's outlier relief per discharge is greater than the computed 60th percentile outlier relief per discharge for all providers in the provider's peer group. The methodology used shall be as follows:

   (a) Using OSHPD patient discharge data, and Medicare criteria for DRG outlier relief as specified in 42 CFR, Part 412, compute the total outlier relief for all providers in each peer group (using the same formula as listed in Section VII. ARPD case mix and outliers). However, the cost outlier cutoff shall not vary within any one FPE worth of data.

   (b) Convert the results under 1) above to outlier relief per Medi-Cal discharge.

   (c) Align the results of (b) above, in order from lowest at the bottom up to the highest at the top, and by counting up from the bottom to the n + 1 provider (n = # of providers in the peer group), compute the 60th percentile outlier relief per discharge for each peer group.

   (d) If the requesting providers outlier relief per discharge is greater than the 60th percentile outlier relief per discharge, the provider's MARD shall be increased by the difference of the two figures.

6) These formulas shall be subject to the following limitations:

   (a) Only those providers with 30 or more Medi-Cal discharges shall be included in the calculation of the 60th percentile outlier and case mix index per discharge. However, providers with under 30 Medi-Cal discharges may still receive relief using the formulas in this Part.

   (b) Providers whose Medi-Cal discharge count per their OSHPD patient discharge data has more than a 50 percent variance from the appropriate Medi-Cal discharge figure from the cost report, after

adjusting for well newborns who are included in the OSHPD patient discharge data but not counted as Medi-Cal discharges, shall be excluded from the 60th percentile calculation. Cost report figures shall be adjusted to estimate the calendar or fiscal period OSHPD data.

(c) If the provider requesting outlier relief has more than a 10 percent variance in Medi-Cal discharge figures (OSHPD patient discharge data vs. Medi-Cal cost report), or under 30 Medi-Cal discharges, the provider shall be required to submit its own data for use in the calculation. Such data must be for all Medi-Cal patients and include the patient's last name, ICD-9 primary diagnosis code, admission date, discharge date, DRG number, charges, patient's age, and OSHPD disposition code. The list shall be in admission date order.

(d) Providers may submit additional data to replace the OSHPD data. Any such data must be supplied with the AAR. Providers must supply a list in admission date order, containing each Medi-Cal patient's last name, ICD-9 code, admission date, discharge date, DRG number, charges, patient's age, and OSHPD disposition code.

7) For noncontracting hospitals that do not keep a patient for the full episode of care, the CMA formula will be modified by one of the following formulas:

(a) Use only 40 percent of the appropriate DRG case mix weight for patients treated by noncontract hospitals, or

(b) (1) Track each patient's record to the contract hospital they were transferred to, and

(2) Sum the charges from both providers, and

(3) Apply the percent of total charges from the noncontract hospital to the DRG weight.

B. Differences in labor costs, caused by factors such as differences in location, between the provider and other providers in its peer group shall be calculated using the following formula, subject to reduction for overlapping issues as specified in D. below:

MARD = (LRCAF * WRR * PGL) + ((1-WRR) * PGL))

Where:

MARD = Maximum Allowable Rate Per Discharge under PGRPDL

LRCAF = Labor Related Cost Adjustment Factor, which is the minimum of (WI / PGWI), (HWR / PGWR) and (HWD / PGWD).

WRR = Wage Related Reimbursement Proportion of PGRPD (and ARPD) Reimbursement limitation for this hospital, which is: (TWRC / GOE) * (36LIMIT - %PASS * NETCOST)) / (36LIMIT * %NON).

PGL = Peer group limit, which is the 60th percentile ARPD.

WI = The wage and benefit index for the area in which the hospital is located.

PGWI = Peer group 60th percentile WI.

HWR = Hospital aligned wage and benefit rate per hour.

PGWR = Peer group 60th percentile HWR.

HWD = Hospital aligned wage related items per discharge.

PGWD = Peer Group 60th percentile HWD.

TWRC = Total wage related costs (sum of wages, benefits, and professional fees).

GOE = Gross operating expenses.

36 LIMIT = Maximum reimbursement under MIRL (lesser of costs, charges, and the ARPD multiplied by the number of Medi-Cal discharges).

%PASS = Proportion of GOE which are pass throughs from Report E, Part II, Line 3.

NETCOST = The lesser of net cost of covered services and charges.
%NON = 1 - %PASS, which is the proportion of GOE which are not pass-through costs.

NOTE: * = Multiplication

1) The labor adjustment formula starts by determining the portion of the MIRL that was allowed for Wage Related Reimbursement (WRR). Only this amount is adjusted by the minimum of:

(a) A ratio based on an area (Metropolitan Statistical Area (MSA)) index developed by the Department of Health and Human Services, calculated using aligned average hourly rates for all hospital employees. The provider's area index is divided by the peer group 60th percentile wage index.

(b) A ratio based on comparing the provider's aligned hourly rate to the 60th percentile aligned hourly rate of the peer group.

(c) A ratio based on comparing the providers aligned wage related items per discharge to the 60th percentile aligned wage related items per discharge for the peer group.

2) The first ratio is calculated as follows:

(a) Use Medi-Cal cost report data to determine the statewide average employee composition among all employee classifications.

(b) Adjust the wage and benefit rates for each provider to the adjusted rate using the statewide distribution of employees.

(c) Align the adjusted wage and benefit rate for each provider using OSHPD disclosure data. The alignment factors shall be a Department estimate of increases in salary levels.

(d) Sum the adjusted wages and benefits for each MSA and statewide.

(e) Sum productive hours by MSA and statewide.

(f) Divide the sum of wages and benefits by the sum of productive hours for each MSA and the statewide totals.

(g) Divide each MSA average aligned hourly wage rate by the statewide average to obtain an MSA index.

(h) Assign the index for each MSA to all hospitals in the MSA.

(i) Determine the 60th percentile index for each Peer Group.

(j) Divide the hospital's area index by the 60th percentile index of its peer group.

3) The second ratio is calculated by:

(a) Total the wages and benefits for all employees for each provider.

(b) Divide (a) above by the corresponding total productive hours for each provider.

(c) The Department shall estimate increases in employee hourly wage and benefit costs, and align the data in (b) above to a common FPE for all providers.

(d) Align all of the results of (c) above ordered from lowest at the bottom to the highest at the top for each peer group.

(e) Count (0.6 * (n + 1)) places up from the bottom of the list in each peer group to find the 60th percentile.

(f) N is the number of hourly rates in the peer group.

(g) Interpolation will be used whenever (0.6 * (n + 1)) is not a whole number.

4) The last ratio is calculated by:

(a) Total the wages and benefits for all employees for each provider.

(b) Using Department estimates of rates of increase in employee hourly wages and benefit costs, align the data in (a) above to a common FPE for all providers.

(c) Divide the result of (b) above by the number of total hospital discharges.

(d) For each peer group, order from lowest at the bottom to the highest at the top the results of (c) above.

(e) Count (.6 * (n + 1)) places up from the bottom of the list in each group to find the 60th percentile.

(f) N is the number of wage and benefit rates per discharge in the peer group.

(g) Interpolation will be used whenever (.6 * (n + 1)) is not a whole number.

C. Differences in capital costs between the provider and other providers in its peer group shall be resolved using the method specified in this subsection. Approval by the OSHPD of a capital expenditure shall be evidence of the need for the capital expenditure; however, such approval shall not, per se, compel additional reimbursement. The following methods shall be used to calculate relief under this issue:

1) Using data from the Medi-Cal cost report, compute relief by:

(a) Removing the 60th percentile capital cost per discharge from the 60th percentile allowable rate per discharge,

(b) Computing the allowable provider Medi-Cal capital expense per discharge subject to the limitations in (e) below, and

(c) Adding the result of (a) above to the result of (b) above.

(d) The resulting figure from (c) above will be used in place of the 60th percentile rate per discharge, but to avoid overlap with any other issue, this adjustment shall be made last.

(e) The result of 1) (b) above shall be subject to the following adjustments:

1. A hospital which has had a change of ownership (CHOW) on or after July 18, 1984, must submit data showing what its capital costs would have been had the CHOW not occurred except for any additional costs allowed under the Deficit Reduction Act of 1984. This capital cost

amount shall be used when computing the provider's capital per discharge figure above.

2. If a provider has had its capital costs reduced by Medicare, the provider's capital expense per discharge (CEPD) shall be reduced by the Medicare capital cost reduction percentage.

   The formula for relief would then be:

   MPGRPD = (PGRPD - 60th percentile CEPD) + (X * hospital CEPD)

   Where: X = 1 minus the Medicare payment reduction percentage

3. If a provider's capital expense per discharge is above the 60th percentile, it shall not be entitled to automatic relief. The provider must still prove that the capital expenses are necessary for the care of Medi-Cal patients.

D. Providers which are eligible for any multiple adjustments under Sections X. through XI. of this Plan shall have relief computed using the following methodologies:

1) For providers which are eligible for case mix, labor and capital adjustments, relief shall be computed as follows:

   MPGRPD = MAX(CMA,LRCAF,MIN ((CMA*(WI/PGWI)),(HWD/PGWD))) * WRR * PGRPD) +

   (CMA * (1 - CRC - WRR) * PGRPD) + CEPD

   Where: CRC = Capital related cost percentage (CEPD/GOE)
   MIN= Minimum of the items in parentheses
   MAX= Maximum of the items in parentheses

   If the provider's CEPD has been modified per Section XI. C. 2. above, that revised figure shall be substituted into the formula above.

2) For providers which are entitled to a CMA but whose capital and/or labor costs per discharge are below the 60th percentile, those cost components shall not be adjusted by the CMF. The formula for relief shall be:

MPGRPD = ((PGRPD - 60th percentile CEPD - 60th percentile
labor per discharge) * CMA) + hospital CEPD +
hospital labor per discharge

(a) This formula shall be modified to remove only those costs (labor and/or capital) which are below the 60th percentile limit.

(b) A provider's reimbursement, pursuant to the above, shall not be adjusted below the 60th percentile rate per discharge.

(c) All other multiple adjustments shall have their overlapping relief calculated using the basic PGARPDL principles.

E. Differences in costs between the provider and other providers in its peer group due to extraordinary events beyond the provider's control such as fire, earthquake, flood, or similar unusual occurrences with substantial cost effects shall be an appealable item;

F. Differences in costs between the provider and other providers in its peer group caused by other items or circumstances affecting provider costs which meet all of the following criteria:

1) The item is a difference, on a per discharge basis, between the hospital and the 60th percentile of the peer group.

2) The item can be measured or estimated for all providers in the peer group.

3) The costs were necessary for the provision of quality medical care to Medi-Cal beneficiaries.

4) There is no overlap with other issues or the overlap can be measured.

G. Relief for any issue shall be reduced for any overlap between issues.

H. Any additional reimbursement granted pursuant to this part of the Plan shall not result in a recalculation of the 60th percentile limit under Section IX. of this Plan.

XII. CONTRACTS

A. The reimbursement limitation for the noncontract service costs of contracting hospitals which had a valid contract during the entire settlement fiscal period shall be determined by the following method:

Noncontract Reduction = NMCN - TCL

Where:

NMCN = Noncontract Medi-Cal net cost of covered services including third-party liability amounts

TCL = PYNCPD * PDL * SYND
PYNCPD = PYNC/PYND

TCL = Total cost limit exclusive of any reductions for third-party liability

PYNCPD = Prior fiscal period noncontract cost per day

PYNC = Prior fiscal period noncontract costs

PYND = Prior fiscal period noncontract days

PDL = Per diem limit increase which shall be the target as specified in federal regulation CFR 42, Section 413.40(c)(3).

SYND = Settlement fiscal period noncontract days

1) All AA and appeal issues must pertain to the reason for the increase in the average noncontract costs per day from the prior fiscal period to the settlement fiscal period.

2) Contracting hospitals with noncontract service costs will also have an ARPDL calculation performed each FPE. The calculation will be used to determine the base period for the next FPE in the event the provider discontinues the contracting program.

B. The noncontract reimbursement reduction, if any, for partial FPE contracting hospitals those hospitals which have gone on or off contracting during their settlement fiscal period, shall be determined as follows:

Noncontract Reduction = PRNC * FYR

Where:

PRNC = NMCN/TMCN

PRNC = Proportion of reimbursement not under contract

FYR = Full fiscal period all services reimbursement reduction as determined by the PIRL.

NMCN = Noncontracting Medi-Cal net cost of covered services

TMCN = Total Medi-Cal net cost of covered services for the entire fiscal period for all services.

XIII. DISPROPORTIONATE SHARE

A. Disproportionate share payments shall be paid in accordance with the provisions of the existing State Plan (pages 18 to 37).

XIV. REIMBURSEMENT LIMITS FOR OUT-OF-STATE HOSPITALS

See Attachment 4.19-A, page 16. Provisions for Out-of-State reimbursement will remain in place on page 16.

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

Reimbursement for Short-Doyle/Medi-Cal (SD/MC) acute inpatient hospital mental health services is either on a retrospective or prospective basis, based on determinations by the Department of Mental Health of individual county operations, and the preference of individual providers. Reimbursement shall be based on the lesser of:

1) Each provider's customary charges.

2) Depending on which reimbursement method the provider is under, each provider's allowable cost or negotiated rate (NR) or negotiated net amount (NNA), both of which are expressed by the established service function and unit of service (i.e., patient day) for providers contracting on an NR or NNA basis pursuant to Section 5705.2 of the

Welfare and Institutions Code.

3) A per diem rate established annually by the Department based on 125 percent of the statewide average of the costs of services as reflected in the most recent provider's cost reports. This rate shall be adjusted annually to reflect any cost of living allowance provided for in the Budget Act.

If application of this per diem rate would result in a substantial inability to provide SD/MC mental health services, the computed rate may be waived by the Department of Mental Health pursuant to Section 5705.1 of the Welfare and Institutions Code, subject to approval by the Department.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO GENERAL ACUTE CARE HOSPITALS FOR ACUTE INPATIENT SERVICES

Notwithstanding any other provision of this State Plan, for admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for nondesignated public hospitals (NDPHs), reimbursement to private and nondesignated public general acute care hospitals (GACH) for acute inpatient services that are provided to Medi-Cal beneficiaries is described and governed by this segment of Attachment 4.19-A.

A. Definitions

1. "APR-DRG" or "All Patient Refined Diagnosis Related Groups" is a specific code assigned to each claim by a grouping algorithm that utilizes the diagnoses code(s), procedure code(s), patient birthdate, patient age, patient gender, admit date, discharge date, and discharge status on that claim.

2. "APR-DRG Base Price" is the statewide base price amount before the relative weight of the APR-DRG, any adjustors, and/or add-on payments are applied. APR-DRG Base Prices are determined by parameters defined in Welfare and Institutions (W&I) Code section 14105.28, as the law was in effect on July 1, 2013.

3. "APR-DRG Grouper" is the software application used to assign the APR-DRG to a DRG Hospital claim.

4. "APR-DRG Payment" is the payment methodology for acute inpatient services provided to Medi-Cal beneficiaries at DRG Hospitals for admissions on or after July 1, 2013, for private hospitals and for admissions on or after Janaury 1, 2014, for NDPHs.

5. " "APR-DRG Hospital-Specific Relative Value" (HSRV) is a numeric value representing the average resources utilized per APR-DRG. The relative weights associated with each APR-DRG are calculated from a two-year dataset of 15 million stays in the Nationwide Inpatient Sample, which includes general acute care hospitals including freestanding children's hospitals.

6. "DRG Hospital Specific Transitional APR-DRG Base Price" is a DRG Hospital specific APR-DRG Base Price calculated to assist DRG Hospitals to adapt to the change in payment methodologies. Transitional base prices are used during the three year implementation phase for qualifying hospitals.

7. "DRG Hospitals" are private general acute care hospitals reimbursed for acute inpatient services based on APR-DRG pricing for admissions dated on or after July 1, 2013, and NDPHs reimbursed for acute inpatient services based on APR-DRG pricing for admissions dated on or after January 1, 2014. "DRG Hospitals" are currently all private and nondesignated pubic general acute care hospitals not excluded as outlined in (Section B; paragraph 2).

8. "Nondesignated public hospital" means a public hospital defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals as that section reads as of of January 1, 2014.

9. "Private hospital" means a nonpublic hospital, nonpublic converted hospital, or converted hospitals, as those terms are defined in paragraphs (26) to (28) of subdivision (a) Section 14105.98 as that section reads as of July 1, 2013.

10. "Estimated Gain" is the amount a DRG Hospital is estimated to gain on a final discharge claim for which the final APR-DRG Payment exceeds estimated costs.

11. "Estimated Loss" is the amount a DRG Hospital is estimated to lose on a final discharge claim for which the final APR-DRG Payment does not exceed estimated costs.

12. "Exempt Hospitals, Services, and Claims" are those hospitals, services, and claims as listed in Paragraph B.2.

13. "High Cost Outlier Threshold 1" is the amount that an estimated loss for a single complete discharge claim must exceed to be paid an outlier payment at the Marginal Cost Factor 1.

14. "High Cost Outlier Threshold 2" is the amount that an estimated loss for a single complete discharge claim must exceed to be paid an outlier payment at the Marginal Cost Factor 2.

15. "Low Cost Outlier Threshold" is the amount that the Estimated Gain needs to be greater than to have the gained amount reduced by Marginal Cost Factor 1.

16. "Marginal Cost Factor 1" is the factor used for payment reductions and for determining outlier payments to DRG Hospitals for claims that have estimated losses between High Cost Outlier Threshold 1 and High Cost Outlier Threshold 2.

17. "Marginal Cost Factor 2" is the factor used for determining outlier payments to DRG Hospitals for claims that have estimated losses greater than High Outlier Threshold 2.

18. "Medi-Cal" is the name of California's Federal Medicaid program.

19. "Remote Rural Hospital" is a California hospital that is defined as a rural hospital by the Office of Statewide Health Planning and Development (OSHPD), is at least fifteen (15)

miles in driving distance from the nearest GAC hopital that has a basic level emergency room, and does not operate under a combined license or bill under a common National Provider Index (NPI) number with a non-remote rural hospital.

20. "State Fiscal Year" (SFY) is California state government's fiscal year which begins on July 1 and ends the following June 30.

21. "Hospital-Specific Wage Area Index Values" are hospital-specific geographic adjustments that Medicare uses (from the Medicare hospital impact file) further adjusted by a factor of 0.9797 for California hospitals.

B. Applicability

1. Except as specified below in Paragraph 2, for admissions dated July 1, 2013 for private hospitals, and after and commencing on admissions dated January 1, 2014, and after for NDPHs, the Department of Health Care Services (DHCS) will reimburse "DRG Hospitals" through a prospective payment methodology based upon APR-DRG.

2. The following are "Exempt Hospitals, Services, and Claims" that are not to be reimbursed based upon APR-DRG:

   a. Psychiatric hospitals and psychiatric units
   b. Rehabilitation hospitals, rehabilitation units, and rehabilitation stays at general acute care hospitals
   c. Designated Public Hospitals
   d. Indian Health Services Hospitals
   e. Inpatient Hospice
   f. Swing-bed stays
   g. Managed Care stays

h. Administrative Day Reimbursement claims

i. Level 1

ii. Level 2

C. APR-DRG Reimbursement

For admissions dated July 1, 2013, and after for private hospitals and for admissions dated January 1, 2014, and after for NDPHs, reimbursement to DRG Hospitals for services provided to Medi-Cal beneficiaries are based on APR-DRG. Effective July 1, 2015, APR-DRG Payment is determined by multiplying a specific APR-DRG HSRV by a DRG Hospital's specific APR-DRG Base Price with the application of adjustors and add-on payments, as applicable. Provided all pre-payment review requirements have been approved by DHCS, APR-DRG Payment is for each admit through discharge claim, unless otherwise specified in this segment of Attachment 4.19-A.

1. APR-DRG HSRV

The assigned APR-DRG code is determined from the information contained on a DRG Hospital's submitted UB-04 or 837I acute inpatient claim. The grouping algorithm utilizes the diagnoses codes, procedure codes, admit date, discharge date, patient birthdate, patient age, patient gender, and discharge status present on the submitted claim to group the claim to one of 314 specific APR-DRG groups. Within each specific group of 314, there are four severities of illness and risk of mortality sub classes: minor (1), moderate (2), major (3), and extreme (4). This equates to a total of 1256 different APR-DRG (with two error code possibilities). Each discharge claim is assigned only one APR-DRG code. For each of the 1256 APR-DRG codes there is a specific APR-DRG HSRV assigned to it by the APR-DRG grouping algorithm. The APR-DRG HSRVs are

calculated from a Nationwide Inpatient Sample. Each version of the APR-DRG grouping algorithm has its own set of APR-DRG specific HSRVs assigned to it. The APR-DRG HSRVs are published in the Medi-Cal DRG Pricing Calculator posted on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

2. APR-DRG Statewide Base Prices Beginning SFY 2016-17

   i. In determining the APR-DRG Payment, California DRG Hospitals and out-of-state hospitals will utilize the statewide APR-DRG Base Price, except for California Remote Rural Hospitals, which will utilize the remote rural APR-DRG Base Price as reflected in Appendix 6 to Attachment 4.19-A.

3. DRG Hospital Specific Transitional APR-DRG Base Prices for SFYs 2013-14 through 2015-16

   a. Similar to implementation of DRGs in Medicare, DHCS is implementing a three-year transition period to allow California DRG Hospitals moving to the APR-DRG Payment methodology to adapt to the change in payment methodologies. A DRG Hospital Specific Transitional APR-DRG Base Price is utilized for qualifying DRG Hospitals for each of SFYs 2013-14, 2014-15, and 2015-16, in accordance with this section. The statewide APR-DRG base rates will be fully utilized by all DRG Hospitals beginning SFY 2016-17.

   b. First year DRG Hospital Specific Transitional APR-DRG Base Prices apply to DRG hospitals that were projected in general to see a change in estimated payments of no more than five percent for private hospitals and no more than 2.5 percent for NDPHsfrom their projected baseline payments. Some DRG Hospitals will receive a

DRG Hospital Specific Transitional APR-DRG Base Prices that is higher than the APR-DRG Statewide Base Price. Other DRG Hospitals will receive a DRG Hospital Specific Transitional APR-DRG Base Price lower than the statewide base price, but with a floor of fifty percent of the statewide base rate (due to the fifty percent floor, some private DRG Hospitals may have increases greater than five percent and some NDPH DRG Hospitals may have increases greater than 2.5 percent).

c. In determining the first year DRG Hospital Specific Transitional APR-DRG Base Price, a twelve month dataset was established using paid claims with discharge dates between January 1, 2009, and December 31, 2009, and paid dates through December 27, 2010, extracted from the CA-MMIS processing system and the 2009 patient discharge dataset from OSHPD. Payments from calendar year (CY) 2009 were trended forward to 2013-14 based on (1) actual contract rate increases for contract hospitals, (2) the hospital fee UPL trend factors for non-contract hospitals, or (3) a combination of these two if a hospital had a change in contract status since 2009; the payment trends for this purpose assume payments for services in SFY 2013-14 are based on rates in effective at the end of SFY 2013. Case mix based on projected actual case mix growth and growth from improved documentation were trended forward from CY 2009 to SFY 2013-14 by 5.85 percent. For outlier payment projection purposes, billed charges from CY 2009 were trended to SFY 13-14 by 28.98 percent, and cost-to-charge ratios were derived from the hospital's latest accepted cost report. The 2009 data set trended forward to 2013-14 as described in this paragraph was utilized to develop 2013-14 DRG base prices. Without further trending or other adjustments, the same data set was also used to develop 2014-15 and 2015-16 transitional base prices.

d. A statewide base price was calculated that would result in the same level of overall payments if all hospitals received the same underlying base price (or the remote rural base price for remote rural hospitals), which was adjusted by the Medicare local wage

area index value reflecting the various hospital-specific adjustments that Medicare uses (from the Medicare hospital impact file).

e. A shadow base price was calculated for each hospital that would result in the same level of projected payments in 2013-14 for each hospital under DRGs as projected under the prior methodology. The wage index was not relevant to this calculation because it was based on setting a final price at a level that results in the same amount of projected payments as under the prior methodology.

f. DRG Hospitals that would have a minimal projected impact will be assigned to the statewide base price or remote rural base price (adjusted by the wage area index value) during the transition period if any of the following apply:

   i. The estimated impact (up or down) on total projected payments of APR-DRG Payment is less than five percent for private hospitals and 2.5 percent for NDPHs.
   ii. If the estimated impact (up or down) on total projected payments of APR-DRG Payment is less than $50,000.
   iii. If the DRG Hospital had fewer than 100 Medi-Cal Fee for Service stays and these stays were estimated to represent less than two percent of the DRG Hospital's total inpatient volume based on data submitted to OSHPD.
   iv. If there were no stays in the simulation dataset for a particular DRG Hospital.

g. For remaining DRG Hospitals that had a shadow base price that results in projected payments above projected payments at the statewide base price (adjusted for their wage area index value), a hospital specific base price was calculated that resulted in a 5 percent reduction in projected payments for private hospitals a one percent reduction in projected payments for NDPHs.. The wage index was not relevant to this calculation because it was based on setting a final price at a level that results in projected payments that are 5 percent less than projected under the prior methodology

for private hospitals and one percent less than projected under the prior methodology for NDPHs. A minimum base price that is 50 percent of the statewide price (adjusted for the wage area index value) was established. DRG Hospitals with a shadow base price below this threshold were increased to this level. To the extent projected savings from the one percent reduction for NDPHs and 5 percent reduction for private hospitals exceeded the projected cost of establishing a floor of 50 percent of the statewide base price, the difference was provided to all remaining transition hospitals (separately for remaining private transition hospitals and remaining NDPH transition hospitals). Remaining hospitals defined as remote, rural hospitals received a base price that will result in a 5 percent increase in projected payments. The remaining non-remote, rural hospitals received base prices that provide for a proportional increase in projected payments, which is approximately 2 percent for private hospitals and 0.5 percent for NDPHs under DRGs in 2013-14 compared to projected 2013-14 payments under the prior methodology. All base prices were rounded to the nearest whole dollar. A hospital specific transitional base price was calculated accordingly for each of these hospitals. Because this final calculation was based on setting payments at a specific level above the shadow base price, the wage area index value was not a consideration.

h. Second year and third year DRG Hospital Specific Transitional APR-DRG Base Prices apply to DRG hospitals that were projected in general to see a change in estimated payments of more than ten percent for private hospitals and 7.5 percent for NDPHs from their projected baseline payments (SFY 2014-15) and fifteen percent from their projected baseline payments (SFY 2015-16). Some DRG Hospitals will receive a DRG Hospital Specific Transitional APR-DRG Base Price that is higher than the APR-DRG Statewide Base Price. Other DRG Hospitals will receive a DRG Hospital Specific Transitional APR-DRG Base Price lower than the statewide base price, but with a floor of fifty percent of the statewide base rate (due to the fifty

percent floor, some DRG Hospitals may have increases greater than five percent in 2013-14).

i. To develop 2014-15 hospital-specific transitional base prices, hospitals with projected payments in 2013-14 above projected payments at the statewide base price had base prices calculated that would result in an additional 5 percent reduction in projected payments as compared to projected baseline payments. To the extent this results in a transitional base price below the statewide base price for a hospital, the hospital receives the statewide base price and therefore receives less than an additional 5 percent reduction in projected payments. Savings that results from the reduction described in this paragraph will be utilized to provide a uniform percentage increase in projected payments for hospitals with projected 2013-14 payments that are less than their projected payments at the statewide base price. However, no hospital shall receive a percentage increase that would result in a transitional base price above the statewide base price.

j. To develop 2015-16 hospital-specific transitional base prices, hospitals with projected payments in 2014-15 (which is the projected 2013-14 payments reduced by 5 percent per subparagraph i above) above projected payments at the statewide base price had base prices calculated that would result in an additional 5 percent reduction (7.5 percent reduction for NDPHs) in projected payments as compared to projected baseline payments. To the extent this results in a transitional base price below the statewide base price for a hospital, the hospital receives the statewide base price and therefore receives less than an additional 5 percent reduction (or 7.5% percent reduction for NDPHs) in projected payments. Savings that results from the reduction described in this paragraph will be utilized to provide a uniform percentage increase in projected payments for hospitals with projected 2014-15 payments that are less than their projected payments at the statewide base price. However, no hospital shall

receive a percentage increase that would result in a transitional base price above the statewide base price.

k. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2013-14 were sent to private hospitals January 30, 2013.

l. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2013-14 were sent to NDPHs June 17, 2013.

m. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2014-15 and SFY 2015-16 was provided to hospitals on July 31, 2013. Transitional APR-DRG Base Prices are subject to change based on changes to the Medicare Wage Index, hospital characteristics or other reasons. The updated DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2015-16 were sent to private hospitals and NDPHs on May 29, 2015, June 2, 2015, and June 3, 2015. Beginning in 2016-17 all hospitals will receive the statewide base price.

4. Wage Area Adjustor

a. The "Wage Area Adjustor" adjusts the APR-DRG Base Price of a DRG Hospital depending on the wage area Medicare has assigned to them. DHCS will utilize the same wage area boundaries, wage area index values, labor share calculation, and any other wage area or index value adjustments as Medicare, but further adjusted by the California Wage Area Neutrality Adjustment of 0.9797 for California hospitals. DHCS will also use the Medicare reclassifications of DRG Hospitals into adjacent wage areas. Out of state hospitals will receive a wage area adjustor of 1.00. The wage area adjustor is applied to the labor share percentage, as specified in Appendix 6, of the statewide base price or the remote rural base price. Medicare published the Medicare impact file for FFY 2015 in January, 2015 and it was used for the transitional base prices for SFY

2015-16. Similarly, final changes to all DRG hospitals wage area, index value, or labor share calculation published for future federal fiscal years will be used for the state fiscal year beginning after the start of each respective federal fiscal year. All wage area index values can be viewed on the Medi-Cal DRG Pricing Calculator posted on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

b. The wage area adjustor is not applied to the hospital-specific transitional base price (determined in paragraph C.3 above).

5. Policy Adjustors

The implementation of APR-DRG Payment includes the functionality of policy adjustors. These adjustors are created to allow the DHCS to address any current, or future, policy goals and to ensure access to care is preserved. Policy adjustors may be used to enhance payment for services where Medi-Cal plays a major role. This functionality of policy adjustors allows DHCS the ability to ensure access to quality care is available for all services. A list of the current policy adjustors is reflected in Appendix 6 of Attachment 4.19-A. These policy adjustors are used to adjust payment weights for care categories. The projected financial impact of the policy adjustors was considered in developing budget-neutral base prices.

6. Cost Outlier Payments

Outlier payments are determined by calculating the DRG Hospital's estimated cost and comparing it to the APR-DRG Payment to see if there is a loss or gain for the hospital for a discharge claim. The DRG Hospital's estimated cost on a discharge claim is determined by multiplying the Medi-Cal covered charges by the DRG Hospital's most currently accepted cost-to-charge ratio (CCR) from a hospital's CMS 2552-10 cost report. The CCR is

calculated from a hospital's Medicaid costs (reported on worksheet E-3, part VII, line 4) divided by the Medicaid charges (reported on worksheet E-3, part VII, line 12). All hospital CCRs will be updated annually on July 1, after the acceptance of the CMS 2552-10 by DHCS.

a. Subtracting the APR-DRG Payment from the DRG Hospital's estimated cost on a given discharge claim gives the estimated loss. If the Estimated Loss is greater than the High Cost Outlier Threshold 1, then the Cost Outlier Payment is the Estimated Loss less the High Cost Outlier Threshold 1 (but to a maximum of High Cost Outlier Threshold 2 less High Cost Outlier Threshold 1) multiplied by the Marginal Cost Factor 1.

b. For extreme outlier cases, if the Estimated Loss on a discharge claim is greater than the High Cost Outlier Threshold 2, then the Cost Outlier Payment is the Estimated Loss less the High Cost Outlier Threshold 1 (but to a maximum of High Cost Outlier Threshold 2 less High Cost Outlier Threshold 1) multiplied by the Marginal Cost Factor 1, plus the Estimated Loss less High Cost Outlier Threshold 2 multiplied by the Marginal Cost Factor 2.

c. APR-DRG Payment also utilizes a low-side outlier similar to the high side outlier adjustment calculations. The estimated gain is determined by subtracting the APR-DRG Payment from the DRG Hospital's estimated cost . If the Estimated Gain is greater than the Low Cost Outlier Threshold, payment will be decreased by the Estimated Gain less the Low Cost Outlier Threshold, and then multiplied by the Marginal Cost Factor 1.

d. Values for High Cost Outlier Threshold 1, High Cost Outlier Threshold 2, Low Cost Outlier Threshold, Marginal Cost Factor 1, and Marginal Cost Factor 2 are reflected in Appendix 6 of Attachment 4.19-A.

7. Transfer Adjustments

When a Medi-Cal beneficiary is transferred from a DRG Hospital (DRG Hospital 1), to another hospital, DRG Hospital 1's payment for the transfer is determined by calculating a per diem payment amount for the assigned APR-DRG and multiplying it by: one plus the actual length of stay. The per diem amount is calculated by pricing the stay at its assigned APR-DRG payment and dividing by the nationwide average length of stay for the assigned APR-DRG. If DRG Hospital 1's actual length of stay plus one is greater than the nationwide average length of stay, payment for this particular transfer would pay the full DRG. If the receiving hospital is a DRG Hospital, they would receive an APR-DRG payment based on a final discharge claim. Discharge status values defining an acute care transfer are reflected in Appendix 6 of Attachment 4.19-A. The various relative weights, including average length of stay are published in the Medi-Cal DRG Pricing Calculator posted on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

8. Interim Payments

For stays exceeding twenty- nine (29) days, a DRG Hospital may submit an interim claim for payment every thirty (30) days. For example, if a stay is for sixty-one (61) days, two interim claims may be submitted for payment, as well as one final claim. Interim claims are paid a per diem amount for each day of service. When the Medi-Cal beneficiary is discharged, the DRG Hospital submits a full admit through discharge claim. The final discharge claim is priced as any other final discharge claim and will be paid accordingly. All previously paid interim payments related to the final discharge claim are removed from the DRG Hospital's next check-write through the remittance advice detail (RAD). The interim per diem amount is reflected in Appendix 6 of Attachment 4.19-A.

9. Separately Payable Services, Supplies, and Devices

   a. A separate outpatient claim may be submitted for certain services, supplies, and devices as determined by DHCS, reflected in Appendix 6 of Attachment 4.19-A, and will be reimbursed in accordance with Attachment 4.19-B.

   b. Professional services furnished by provider-based physicians and practitioners should be billed as professional claims and are reimbursed outside of the DRG reimbursement. All physician professional services should be billed as professional claims.

10. Out-of-State Hospital Reimbursement

   a. For admissions beginning July 1, 2013, when acute inpatient medical services are provided out-of-state pursuant to Section 2.7 of the State Plan and have been certified for payment at the acute level of an emergency nature for which prior Medi-Cal authorization has been obtained, then such inpatient services are reimbursed utilizing the statewide APR-DRG Base Price for the services provided.

   b. When Medi-Cal is required to provide acute inpatient services that are not available in the State to comply with paragraph (3) of part 431.52(b) of Title 42 of the Code of Federal Regulations, and the out-of-state hospital refuses to accept the APR-DRG rate, then DHCS may negotiate payment in excess of the APR-DRG rate for the acute inpatient services provided but no more than what the out-of-state hospital charges the general public.

   c. DHCS will adjust payment to out-of-state inpatient hospitals for provider preventable conditions, as described in Attachment 4.19-A. When treating a Medi-Cal

beneficiary, out-of-state providers must comply with the reporting provisions for provider preventable conditions described in Attachment 4.19-A pages 52 through 54, OMB No. 0938-1136.

D. Updating Parameters

1. DHCS will review all base prices, policy adjustors, and other payment parameters as needed to ensure projected payments for any given year are kept within the parameters as defined in Welfare & Institutions Code section 14105.28, as the law was in effect on July 1, 2013. Any needed changes may be implemented as outlined in paragraph 4 of this section.

2. The APR-DRG HSRVs are specific to the APR-DRG Grouper version and are released annually. DHCS will perform a review of each released version to determine if an update to the current grouper and hospital acquired condition (HAC) utility are necessary. The APR-DRG Grouper version and HAC Utility version DHCS is utilizing is reflected in Appendix 6 of Attachment 4.19-A. Changes to the APR-DRG Grouper version and HAC Utility version may be implemented pursuant to an approved State Plan Amendment.

3. DHCS will review and update Appendix 6 of Attachment 4.19-A as necessary and pursuant to an approved State Plan Amendment. When reviewing, DHCS shall consider: access to care for specific and overall care categories, hospital coding trends, and any other issues warranting review.

4. The effect of all transition base rates, policy adjustors and values as referenced in Appendix 6 of Attachement 4.19A will be monitored by DHCS on a quarterly basis. If DHCS determines that adjustments to any values or parameters specified in

Appendix 6 of Attachment 4.19-A are necessary to ensure access for all Medi-Cal beneficiaries, program integrity, or budget neutrality, DHCS may adjust those values or parameters upon approval of a State Plan Amendment.

E. Pre-Payment and Post-Payment Review

1. All claims paid using the APR-DRG Payment methodology are subject to DHCS' pre-payment medical necessity review and discretionary post-payment review.

2. Outlier claims may be subject to post-payment review and adjustment in accordance with the following protocols:
   i. Amounts paid for services provided to Medi-Cal beneficiaries shall be audited by the department in the manner and form prescribed by the department as defined in Welfare and Institutions Code 14170.

   ii. When there is a material change between the reported CCR and the final audited CCR, outlier payments may be subject to recalculation based upon the audited CCR. A material change is defined as a change that would result in outlier payment adjustments exceeding $10,000.00 in a hospital's fiscal year

   iii. . Final Audited CCR shall be taken from the audited cost report which overlaps the hospital fiscal year meeting the material change parameters defined in Pre-Payment and Post-Payment Review section E(2)(ii).

F. End of the Selective Provider Contracting Program

Effective July 1, 2013, for private hospitals and January 1, 2014, for NDPHs, the Selective Provider Contracting Program (SPCP) will be discontinued. Reimbursement for hospital inpatient services provided to Medi-Cal beneficiaries will be based on the new diagnosis-related group (DRG) methodology. As part of this, the SPCP will no longer be in effect and is discontinued upon DRG implementation. Additionally, hospitals will no longer be designated as contract or non-contract facilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO HOSPITALS FOR ADMINISTRATIVE LEVEL 1 SERVICES

Notwithstanding any other provision of this State Plan, for admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for NDPHs, reimbursement for Hospital Administrative Level 1 Services that are provided to Medi-Cal beneficiaries by general acute care hospitals is described and governed by this segment of Attachment 4.19-A.

A. Definitions

"Administrative Level 1 Services" are defined as services provided by acute inpatient providers for services rendered to a patient awaiting placement in a Nursing Facility Level-A or Nursing Facility Level B, that are billed under the existing methodology and criteria associated with revenue code 169, as outlined in the Medi-Cal Provider Manual's Inpatient Services "Administrative Days", and as defined in Welfare and Institutions Code section 14091.21, as they were in effect on July 1, 2013.

B. Applicability

For admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for NDPHs, the Department of Health Care Services (DHCS) will reimburse acute inpatient providers for Administrative Level 1 Services through an Administrative Day Level 1 per diem payment.

C. Administrative Day Level 1 Reimbursement

Payment for Administrative Day Level 1 Services follow the current DP/NF-B payment methodology used for DP/NF-Bs services for beneficiaries as outlined in Attachment 4.19-D of the State Plan and section 51542 of Title 22 of California Code of Regulations. Hospitals without a DP/NF-B will receive the statewide median rate.

D. Updating Parameters

Rates paid to DP/NF-Bs for services to Medi-Cal beneficiaries are currently reviewed and updated by DHCS in accordance with Attachment 4.19-D. Administrative Day Level 1 rates will be updated concurrently when DHCS releases subsequent state fiscal year DP/NF-B rates.

E. Pre-Payment and Post Payment Review

All claims paid under Administrative Day Level 1 are subject to DHCS' pre-payment medical necessity review and discretionary post-payment review.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO DRG HOSPITALS FOR ADMINISTRATIVE LEVEL 2 SERVICES

Notwithstanding any other provision of this State Plan, for admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for NDPHs, reimbursement for Diagnosis Related Group (DRG) Hospital Administration Level 2 Services that are provided to Medi-Cal beneficiaries by DRG Hospitals is described and governed by this segment of Attachment 4.19-A.

A. Definitions

1. "Administrative Level 2 Services" are defined as services provided by a DRG Hospital requiring more services, supplies, and/or resources than needed for the current administrative day that are billed under the existing methodology and criteria associated with revenue code 169, as outlined in the Medi-Cal Provider Manual's Inpatient Services "Administrative Days," but less than or equal to those required for a Sub-Acute environment as outlined in Attachment 4.19-D of the State Plan.

2. "DRG Hospitals" as defined in Attachment 4.19-A.

B. Applicability

1. For admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for NDPHs, the Department of Health Care Services (DHCS)

will reimburse DRG Hospitals for Administrative Level 2 Services through an Administrative Day Level 2 per diem payment.

2. For admissions dated July 1, 2013, and after, the Department of Health Care Services (DHCS) will reimburse all non-DRG Hospitals for Administrative Level 2 Services as a general acute care stay based on their current reimbursement methodology.

C. Administrative Day Level 2 Reimbursement

For a hospital that operates a distinct part sub-acute facility, payment for Administrative Day Level 2 Services will be at the lower of the current statewide median Sub-Acute rate or the facility-specific cost rate used for distinct part sub-acute facilities providing sub-acute services for both pediatric and adult Medi-Cal beneficiaries as outlined in Attachment 4.19-D of the State Plan. Each of the pediatric and adult Administrative Day Level 2 rate is the average of the respective Sub-Acute ventilator and non-ventilator rates.

For a hospital that does not operate a distinct part sub-acute facility, payment for Administrative Day Level 2 services will be at the current statewide median Sub-Acute rate used for distinct part sub-acute facilities providing sub-acute services for both pediatric and adult Medi-Cal beneficiaries as outlined in Attachment 4.19-D of the State Plan. Each of the pediatric and adult Administrative Day Level 2 rate is the average of the respective Sub-Acute ventilator and non-ventilator rates.

D. Updating Parameters

Pediatric and adult sub-acute rates paid to distinct part facilities providing sub-acute services to Medi-Cal beneficiaries are currently reviewed and updated by DHCS in accordance with Attachment 4.19-D. Administrative Day Level 2 rates will be updated concurrently when DHCS releases subsequent state fiscal year sub-acute rates.

E. Pre-Payment and Post Payment Review

All claims paid under Administrative Day Level 2 are subject to DHCS' pre-payment medical necessity review and discretionary post-payment review.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO DRG HOSPITALS FOR REHABILITATION SERVICES

Notwithstanding any other provision of this State Plan, for admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for NDPHs, reimbursement for Rehabilitation Services that are provided to Medi-Cal beneficiaries by Diagnosis Related Group (DRG) Hospitals is described and governed by this segment of Attachment 4.19-A.

A. Definitions

1. "DRG Hospitals" as defined in Attachment 4.19-A.

2. "Rehabilitation Services" are defined as acute inpatient intensive rehabilitation services provided to Medi-Cal beneficiaries, in accordance with Sections 14064 and 14132.8 of the Welfare and Institutions Code as the laws were in effect on July 1, 2013.

B. Applicability

For admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for NDPHs, the Department of Health Care Services' (DHCS) will reimburse Rehabilitation Services rendered by DRG Hospitals, through a per diem rate for Rehabilitation Services provided to a Medi-Cal beneficiary.

C. Rehabilitation Reimbursement

Provided all requirements for prepayment review have been approved by DHCS, Rehabilitation Services are paid a per diem amount for each day of service that is authorized, unless otherwise specified in Attachment 4.19-A. The specific per diem rates for pediatric and adult rehabilitation services are specified in Appendix 6 and are statewide rates. The specific pediatric and adult rehabilitation per diem rates were set at a level that is budget neutral on a statewide basis for both adult and pediatric rehabilitation services based on rates in effect June 30, 2013. The specific per diem rate for a hospital that provided services to both the adult and pediatric population is based on the blend of pediatric and adult rehabilitation services provided at that specific hospital. A facility-specific blended rate is the weighted average of the statewide adult and statewide pediatric per diem rates, weighted by the individual facility's number of adult and pediatric rehabilitation days in the base period used to determine the statewide per diem rates. The labor portion (69.6%) of all rehabilitation rates are further adjusted by the Medicare Wage Index value for each specific hospital.

D. Updating Parameters

DHCS will review and update the Rehabilitation Services payment parameters through the State Plan Amendment process. When reviewing and updating, DHCS shall consider: access to care related to Rehabilitation Services provided at a DRG Hospital, and any other issues warranting review.

E. Pre-Payment and Post Payment Review

All claims paid under the rehabilitation per diem are subject to DHCS' pre-payment medical necessity review and discretionary post-payment review.