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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

MAY 31 2013

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

RE: California State Plan Amendment 13-004

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 13-004. This amendment provides that inpatient hospital services furnished by private hospitals will be reimbursed under an All Patient Refined Diagnosis Related Group (APR-DRG) prospective payment methodology, effective July 1, 2013.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment TN 13-004 is approved effective July 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Mark Wong 744-3561 or Annalisa Fichera at 415-744-3577.

Sincerely,

Cindy Mann
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **13-004**

2. STATE: **CA**

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2013

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

☒ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447, Subpart C. 1902(a)(13), 1923, 1861(v)(1)(G) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2013/~~14~~ $ ~~(44,083,000)~~ (12,605,537)
b. FFY 2014/~~15~~ $ ~~(89,621,000)~~ (50,422,147)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 17.38–~~17.53~~ 17.61
Appendix 6 to Attachment 4.19-A pages 1-2 3
Limitations on Attach 3.1-A, pages 1, 1a, and 1b
Limitations on Attach 3.1-B, pages 1, 1a, and 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~None~~
Limitations on Attach 3.1-A, pages 1, 1a, and 1b
Limitations on Attach 3.1-B, pages 1, 1a, and 1b

10. SUBJECT OF AMENDMENT:

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: APR 15 2013

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 31 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Penny Thompson

22. TITLE:
Deputy Director, Policy & Financial Mgt., CMCS

23. REMARKS:
Pen-and-ink changes made to Boxes 7, 8 and 9 by Regional Office with concurrence by state dated 5/29/2013

FORM HCFA-179 (07-92)

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, reimbursement to private 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 admissions on or after July 1, 2013 for acute inpatient services provided to Medi-Cal beneficiaries at DRG Hospitals.

5. "APR-DRG Relative Weight" 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 15.5.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. "DRG Hospitals" are currently all private general acute care hospitals not excluded as outlined in (Section B; paragraph 2).

8. "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.

9. "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.

10. "Exempt Hospitals, Services, and Claims" are those hospitals, services, and claims as defined in Welfare & Institutions Code section 14105.28, as the law was in effect on July 1, 2013.

11. "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.

12. "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.

13. "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.

14. "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.

15. "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.

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

17. "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.

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

B. Applicability

1. Except as specified below in Paragraph 2, for admissions dated July 1, 2013 and after, 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 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. Non-Designated Public Hospitals
   e. Indian Health Services Hospitals
   f. Inpatient Hospice
   g. Swing-bed stays
   h. Managed Care stays
   i. Administrative Day Reimbursement claims
      i. Level 1
      ii. Level 2

3. For Medi-Cal Managed Care, as required by Welfare & Institutions Code 14091.3 (c) (2), emergency out-of-network stays are priced by APR-DRGs.

C. APR-DRG Reimbursement

For admissions dated July 1, 2013 and after, reimbursement to DRG Hospitals for services provided to Medi-Cal beneficiaries are based on APR-DRG. APR-DRG Payment is determined by multiplying a specific APR-DRG relative weight 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 Relative Weight

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 Relative Weight assigned to it by the APR-DRG grouping algorithm. The APR-DRG Relative Weights are calculated from a Nationwide Inpatient Sample. Each version of the APR-DRG grouping algorithm has its own set of APR-DRG specific relative weights assigned to it. The APR-DRG relative weights 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 SFY 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 more than five percent from 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 DRG Hospitals are may have increases greater than five 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 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 13-14 by 5.85%. For outlier payment projection purposes, billed charges from CY 2009 were trended to SFY 13-14 by 28.98%, 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.

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. 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. A minimum base price that is 50 percent of the statewide price (adjusted for the hospital-specific 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 5 percent reduction 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. 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, whichis approximately

2 percent 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 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 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 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 hospitals January 30, 2013.

l. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2014-15 and SFY 2015-16 will be provided to hospitals no later than July 31, 2013. 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. 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 2013 in October, 2012 and it was used for the transitional base prices for state Fiscal Year (SFY) 2013-14. 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 on a quarterly basis 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 Relative Weights 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 purusant 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 for a hospital during a state fiscal year.

F. End of the Selective Provider Contracting Program

Effective July 1, 2013, the Selective Provider Contracting Program (SPCP) will be discontinued for private hospitals. 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 Selective Provider Contracting Program 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, 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, 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, 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, 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 serivces 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, 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, 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 a pre-payment 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. All rehabilitation rates are further adjusted by the labor portion (68.8%) of the hospital-specific 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Appendix 6

1. APR-DRG Payment Parameters

Parameter	Value	Description
Remote Rural APR-DRG Base Price	$10,218	Statewide Remote Rural APR-DRG Base Price
Statewide APR-DRG Base Price	$6,223	Statewide APR-DRG Base Price (non-Remote Rural)
Policy Adjustor - Age	1.25	Policy Adjustor for claims whose patients are less than 21 years old with a DRG in the 'miscellaneous pediatric' or 'respiratory pediatric' care categories.
Policy Adjustor – NICU services	1.25	Policy Adjustor for all NICU DRGs (i.e. DRGs assigned to the 'neonate' care category, except for those receiving the NICU Surgery policy adjuster below).
Policy Adjustor – NICU surgery	1.75	Enhanced Policy Adjustor for all designated NICU facilities and surgery sites recognized by California Children's Services (CCS) Program to perform neonatal surgery. For all DRGs assigned to the neonate care category
Policy Adjustor – Each other category of service	1.00	Policy adjustor for each other category of service.
Wage Index Labor Percentage	68.8%	Percentage of DRG Base Price or Rehabilitation per diem rate adjusted by the wage index value.
High Cost Outlier Threshold 1	$40,000	Used to determine Cost Outlier payments
High Cost Outlier Threshold 2	$125,000	Used to determine Cost Outlier payments
Low Cost Outlier Threshold 1	$40,000	Used to determine Cost Outlier payments
Marginal Cost Factor 1	60%	Used to determine Cost Outlier payments
Marginal Cost Factor 2	80%	Used to determine Cost Outlier payments
Outlier Percentage, upper bound	18%	Outlier payments as percentage of total
Outlier Percentage, lower bound	16%	Outlier payments as percentage of total
Casemix Corridor, upper bound	0.6684	Projected upper bound of patient acuity
Casemix Corridor, lower bound	0.6484	Projected lower bound of patient acuity
Discharge Status Value 02	02	Transfer to a short term hospital
Discharge Status Value 05	05	Transfer to a designated cancer center
Discharge Status Value 65	65	Transfer to a psychiatric hospital
Discharge Status Value 66	66	Transfer to a critical access hospital

Interim Payment	$600	Per diem amount for Interim Claims
APR-DRG Grouper Version	V29	3M Software version used to group claims to a DRG
HAC Utility Version	V30	3M Software version of the Healthcare Acquired Conditions Utility
Pediatric Rehabilitation Rate	$1,842	Daily rate for rehabilitation services provided to a beneficiary under 21 years of age on admission.
Adult Rehabilitation Rate	$1,032	Daily rate for rehabilitation services provided to a beneficiary 21 years of age or older on admission.

2. Separately Payable Services, Devices, and Supplies

Code	Description
Bone Marrow	
38204	Management of recipient hematopoietic progenitor cell donor search and acquisition
38204	Unrelated bone marrow donor
Blood Factors	
J7180	Blood factor XIII
J7183/J7184/Q2041	Blood factor Von Willebrand –injection
J7185/J7190/J7192	Blood factor VIII
J7186	Blood factor VIII/ Von Willebrand
J7187	Blood factor Von Willebrand
J7189	Blood factor VIIa
J7193/J7194/J7195	Blood factor IX
J7197	Blood factor Anti-thrombin III
J7198	Blood factor Anti-inhibitor

3. **List of Hospitals to receive the "Policy Adjustor – NICU Surgery"**

1) California Hosp Medical Center of Los Angeles
2) California Pacific Medical Center - Pacific
3) Cedars Sinai Medical Center
4) Children's Hospital & Research Center of Oakland
5) Children's Hospital of Central California
6) Children's Hospital of Los Angeles
7) Children's Hospital of Orange County
8) Citrus Valley Medical Central – Queen of the Valley
9) Earl & Lorraine Miller Children's Hospital
10) Good Samaritan – Los Angeles

11) Good Samaritan - San Jose
12) Huntington Memorial Hospital
13) Kaiser Permanente Medical Center - Oakland
14) Kaiser Foundation Hospital - Roseville
15) Loma Linda University Medical Center
16) Lucille Salter Packard Children's Hospital - Stanford
17) Pomona Valley Hospital Medical Center
18) Providence Tarzana
19) Rady Children's Hospital - San Diego
20) Santa Barbara Cottage Hospital
21) Sutter Memorial Hospital

For purposes of receiving the NICU policy adjustor, the hospital stay must be assigned to the neonate care category. For purposes of receiving the enhanced NICU Surgery policy adjustor, the hospital must meet the definition of a Regional NICU as defined in the CCS Manual of Procedures, Section 3.25.1 or a Community NICU with a neonatal surgery as defined in the CCS Manual of Procedures Sections 3.25.2.

Periodic reviews of CCS-approved NICUs may be conducted on an annual basis or as deemed necessary by the CCS program. If an NICU does not meet CCS program requirements, the NICU may be subject to losing CCS approval. If a hospital loses CCS approval as a designated NICU, the hospital will no longer qualify for the enhanced DRG Policy Adjustor – NICU surgery and be dropped from the list above. Additionally, hospitals that apply and receive NICU approval from CCS will be added to the list above.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1. Inpatient hospital services	Inpatient services are covered as medically necessary except that services in an institution for mental disease are covered only for persons under 21 years of age or for persons 65 years of age and over. It includes Administrative Day Level 1 and Administrative Day Level 2 Services. Administrative Day Level 1 and Level 2 Services are inpatient hospital services provided to a beneficiary who has been admitted to the hospital for general acute care inpatient services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for general acute care inpatient services due to a temporary lack of placement options to a nursing home, subacute, or post acute care that is not yet available that meets the needs of the beneficiary. The beneficiary must meet a nursing home level A or nursing home level B level of care to be eligible for Administrative Day Level 1 Services and subacute care to be	Prior authorization is required for all nonemergency hospitalization except for the first two days of obstetrical delivery or subsequent newborn care services. Certain procedures will only be authorized in an outpatient setting unless medically contraindicated.

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1. Inpatient hospital services (Continued)	eligible for Administrative Day Level 2 Services.	
	Services in the psychiatric unit of a general hospital are covered for all age groups.	Emergency admissions are exempt from prior authorization, but the continuation of the hospital stay beyond the admission is subject to prior authorization by the Medi-Cal Consultant.
	It includes Psychiatric Inpatient Hospital Services.	Beneficiaries must meet medical necessity criteria.
	Psychiatric Inpatient Hospital Services are both acute psychiatric inpatient hospital services and administrative day services provided in a hospital.	
	Acute psychiatric inpatient hospital services are those services provided by a hospital to beneficiaries for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.	
	Administrative day services are psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the	

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

(Note: This chart is an overview only) Limitations on Attachment 3.1-A

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1. Inpatient hospital services (Continued)	hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options and non-acute residential treatment facilities that meet the needs of the beneficiary. Psychiatric Inpatient Hospital Services are provided in accordance with 1902(a)(20)(A),(B), (C) and 1902(a)(21) of the Social Security Act (the Act) for beneficiaries ages 65 and over and with 1905(a)(16) and (h) of the Act for beneficiaries under age 21.	

*Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1. Inpatient hospital services	Inpatient services are covered as medically necessary except that services in an institution for mental disease are covered only for persons under 21 years of age or for persons 65 years of age and over. It includes Administrative Day Level 1 and Administrative Day Level 2 Services. Administrative Day Level 1 and Level 2 Services are inpatient hospital services provided to a beneficiary who has been admitted to the hospital for general acute care inpatient services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for general acute care inpatient services due to a temporary lack of placement options to a nursing home, subacute, or post acute care that is not yet available that meets the needs of the beneficiary. The beneficiary must meet a nursing home level A or nursing home level B level of care to be eligible for Administrative Day Level 1 Services and subacute care to be	Prior authorization is required for all nonemergency hospitalization except for the first two days of obstetrical delivery or subsequent newborn care services. Certain procedures will only be authorized in an outpatient setting unless medically contraindicated.

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	It includes Psychiatric Inpatient Hospital Services.	Beneficiaries must meet medical necessity criteria.
	Psychiatric Inpatient Hospital Services are both acute psychiatric inpatient hospital services and administrative day services provided in a hospital.	
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1. Inpatient hospital services (Continued)	hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options and non-acute residential treatment facilities that meet the needs of the beneficiary. Psychiatric Inpatient Hospital Services are provided in accordance with 1902(a)(20)(A),(B), (C) and 1902(a)(21) of the Social Security Act (the Act) for beneficiaries ages 65 and over and with 1905(a)(16) and (h) of the Act for beneficiaries under age 21.	

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