# CALIFORNIA

## PHYSICIAN AND NON-PHYSICIAN PRACTITIONER

## TIME STUDY IMPLEMENTATION PLAN

## STATE PLAN AMENDMENT 05-023
## &
## MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION
## (No. 11-W-00193/9)

California Department of Health Care Services
Safety Net Financing Division
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**PHYSICIAN AND NON-PHYSICIAN PRACTITIONER TIME STUDY IMPLEMENTATION PLAN**

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# I. INTRODUCTION

This document contains a detailed Implementation Plan (Plan) for physicians and non-physician practitioner time studies (time studies) required under State Plan Amendment (SPA) 05-023. The time studies provided for in this Plan are designed to be used for claiming uncompensated Medicaid costs of providing physician and non-physician practitioner professional services to Medi-Cal beneficiaries by the government-operated hospitals or the government entities with which they are affiliated (including affiliated government-operated physician practice groups). These providers are also known as designated public hospitals (DPHs), and are specified in the SPA.

The time studies also will be used to claim uncompensated costs incurred by DPHs for providing physician and non-physician practitioner professional services to the uninsured, as specified in Attachment F to the Special Terms and Conditions (STCs) of the section 1115 *Medi-Cal Hospital/Uninsured Care Demonstration* (No. 11-W-00193/9) (hospital financing waiver or waiver)

This Plan has been developed by the Department of Health Care Services (DHCS) in consultation with, and approval from, the Federal Centers for Medicare & Medicaid Services (CMS).

# II. BACKGROUND

On December 21, 2007, CMS approved SPA 05-023, which allows for interim, supplemental payments to DPHs to reimburse them for the uncompensated cost of providing physician and non-physician practitioner professional services related to Medicaid inpatient and outpatient care to Medi-Cal beneficiaries. This SPA is effective retroactive to July 1, 2005. These interim supplemental payments approximate the difference between the fee-for-service (FFS) payments received by the DPHs and the actual reimbursable Medicaid costs incurred by the DPHs related to the professional or clinical component of physician or non-physician practitioner services eligible for Federal financial participation (FFP). The *Milestones Document* within SPA 05-023, required time studies to be conducted to account for clinical time for physician and non-physician practitioners in the non-University of California settings utilizing the Medicare approved time study, or in the University of California setting utilizing the methodology detailed in SPA 05-023.

In addition, CMS approved the cost finding methodology established in SPA 05-023 for inclusion in Attachment F of the STCs entitled *Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool* for the purpose of identifying uncompensated costs associated with physicians and non-physician practitioner professional or clinical services related to uninsured inpatient and outpatient care, and for claiming the DPHs' certified public

expenditures (CPEs) against the Safety Net Care Pool (SNCP) established under the waiver.

Senate Bill (SB) 1100 (Stats 2005, ch.560), commencing with Article 5.2 of Chapter 7, Division 9 of the Welfare and Institutions (W&I) Code, was enacted to provide the statutory framework for the waiver, which is effective September 1, 2005, through August 31, 2010.

## III. Plan Goals, Principles, and Application

### A. The goals of the Plan are to:

1. Sufficiently document requirements, timeframes, methodologies, and training requirements and materials.
2. Establish and implement approved time studies to account for professional or clinical time of physician and non-physician practitioners for proper apportionment for claiming under SPA 05-023.
3. Account for 100 percent of provider or non-clinical time for proper cost apportionment for claiming under the waiver.
4. Ensure interim supplemental payments are supported by adequate and auditable documentation.
5. Assure no duplicate payments.

**The following physician and non-physician practitioner costs are allowable for reimbursement under this Plan:**

1. Uncompensated physician and non-physician practitioner professional or clinical services for the purpose of providing inpatient and outpatient care to Medi-Cal recipients.
2. Uncompensated physician and non-physician practitioner professional or clinical services for the purpose of providing inpatient and outpatient care to the uninsured.
3. Uncompensated physician and non-physician practitioner professional or clinical services for the purpose of providing inpatient and outpatient psychiatric care to Medi-Cal recipients and the uninsured.

DHCS will administer the reimbursement of physician and non-physician practitioner services in accordance with Medicare and Medicaid cost principles, and the cost finding methodologies as established in the STCs and SPA 05-023.

### B. <u>Principles of the Plan</u>

The following principles guide the implementation of the Plan:

1. Activities must be adequately captured to ensure proper apportionment to professional or clinical and provider or non-clinical components, and non-allowable activities.
2. Time study methodology must capture 100 percent of time for participants for the period being measured.
3. Time studies must meet the requirements to constitute statistically valid samples, if sampling is used to represent the results of the time study for a specific participant universe.
4. Monitoring of potential for “duplicative” payments.
5. Coordination of activities is expected between the DPHs and other government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups agencies related to activities performed.
6. CMS reviews and approves programs and codes as meeting regulatory requirements as set forth in this Plan.

## C. Time Study Application

The following DPHs and the government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups will perform the following approved time studies:

State Government-operated University of California (UC) Hospitals

UC Davis Medical Center
UC Irvine Medical Center
UC San Diego Medical Center
UC San Francisco Medical Center
UC Los Angeles Medical Center
Santa Monica UCLA Medical Center

State Government-operated UC Hospitals will use the time studies specific to the UCs for physician and non-physician practitioners, and will apply the cost finding methodology established in the STCs and SPA 05-023.

Non-State Government-operated Hospitals (Non-UC)

Los Angeles County Harbor/UCLA Medical Center
Los Angeles County Martin Luther King Jr./Drew Medical Center (for the period July 1, 2005 through August 15, 2007 only)
Los Angeles County Olive View Medical Center
Los Angeles County Rancho Los Amigos National Rehabilitation Center
Los Angeles County University of Southern California Medical Center

Non-State Government-operated hospitals will use the approved Medicare time study for physicians, will use the time study for non-physician practitioners, and will apply the cost finding methodology established in the STCs and SPA 05-023.

Other Government-Operated Hospitals (Non-UC)

Alameda County Medical Center
Arrowhead Regional Medical Center
Contra Costa Regional Medical Center
Kern Medical Center
Natividad Medical Center
Riverside County Regional Medical Center
San Francisco General Hospital
San Joaquin General Hospital
San Mateo County General Hospital
Santa Clara Valley Medical Center
Tuolumne General Hospital (for the period July 1, 2005 through June 30, 2007 only)
Ventura County Medical Center

Other Government-Operated Hospitals will use the approved Medicare time study for physicians, will use the time study for non-physician practitioners, and will apply the cost finding methodology established in the STCs and SPA 05-023.

# IV. PRINCIPLES OF CLAIMING

## A. General Information

Physician and non-physician practitioners may provide services and perform activities that fall into three specific components for the purpose of establishing proper claiming under Medicare and Medicaid cost principles. The three specific components are the clinical or professional component that is related to direct patient care services; the non-clinical or provider component that is related to services that are performed for the benefit of the provider with whom a physician or non-physician is associated; and other non-allowable activities. The unreimbursed clinical or professional component costs that are allowable under Medicare and Medicaid cost principles may be reimbursable under SPA 05-023. The unreimbursed non-clinical or provider component costs may be claimed under the waiver using an appropriate reimbursement mechanism and methodology. The time study is the primary mechanism and methodology for identifying and categorizing services and activities performed by physician and non-physician practitioners.

The activity/object codes in the time study represent the actual duties and responsibilities of the participants, consistent with the operational principles discussed below. Activity/object codes are used to allocate costs for reimbursement purposes under SPA 05-023 and waiver.

## B. Operational Principles

### 1. Application of Cost Principles

In order for the cost of the physician and non-physician practitioners to be reimbursable under SPA 05-023 and the waiver, the activities related to physician and non-physician practitioners must be those that are identified as allowable under Medicare and Medicaid cost principles, and/or be identified as allowable under Attachment D of the STCs.

To the extent that a DPH has identified a physician and/or non-physician practitioner's activities as non-allowable for the purpose of cost claiming, and has identified the physician and/or non-physician practitioner as exempt from participating in the time study, the cost associated with the physician and/or non-physician practitioner will not be included in the DPHs' Interim Hospital Payment Rate Workbook (Workbook), a tool developed for reimbursement under the waiver.

### 2. Capture 100 Percent of Time

In order to correctly identify the time and activities that are apportioned to the clinical or professional, and non-clinical or provider components and other non-allowable activities, an accepted allocation methodology, or time study, must be used. The time study must incorporate a comprehensive list of the activities performed by the physician and non-physician practitioners whose costs are to be claimed under the SPA and waiver. Specifically, the time study must reflect all of the time and activities *(whether allowable or unallowable for claiming)* performed by all physicians and non-physician practitioners providing services at a DPH and/or at a facility for which a DPH is claiming CPE under SPA 05-023 or waiver.

The time study mechanism must entail careful documentation of all services provided, and work performed, by physicians and non-physician practitioners over a set period of time and is used to identify, measure, and allocate time that is attributable to the physician clinical or professional and non-clinical or provider components and non-allowable activities. The unique responsibilities and functions performed by the time study participants, as well as the specific types of activities, are accounted for and included in the time study activity/object codes. Activity/object codes, while not specific to all participants of the time study, are verified against the participant's classification and work/duty schedule to ensure that all activities being performed are identified and incorporated into the codes.

### 3. Coding Structure

The time study activity/object codes must capture all activities performed by time study participants, must identify activities performed that are specific to the participants level of clinical or professional duties and non-clinical or provider duties, must identify activities that are clinical and professional, or non-clinical or provider related, and must identify services that are not allowable and therefore, not reimbursable. Non-allowable activities that are non-reimbursable are identified as those activities that are not related to providing services at a DPH and/or at a facility for which a DPH is claiming CPE under SPA 05-023 and waiver.

## 4. Assure No Duplicate Payments

Federal, state and local governmental resources should be expended in the most cost-effective manner possible. In determining the physician and non-physician practitioner services costs that are reimbursable under SPA 05-023 and waiver, duplication of CPEs for the purpose of reimbursement and duplicate payments are not allowable. DPHs may not claim FFP for the costs of allowable physician and non-physician practitioner services that have been, or should have been, reimbursed through an alternative mechanism or funding source. DPHs must provide assurance to DHCS of non-duplication through their Workbooks and the claiming process.

***Examples for which the costs may not be claimable as physician and non-physician practitioner cost due to the potential for duplicate CPE claiming:***

- Activities and/or services that been billed for **by** the physician and/or non-physician practitioner, and been compensated in full **to** the physician according to federal or state laws, rules, or regulations.
- Activities and/or services that have been compensated, but have not been sufficiently offset by a payment on the Workbook.
- Activities and/or services that have not been fully and accurately reported in the time study.
- Activities and/or services that have been compensated by a third party not related to activities/and or services under SPA 05-023 or waiver, and have not been sufficiently offset by a payment.
- Activities and/or services that are included as part of a managed care rate and are reimbursed by the managed care organization.
- Activities for which the charges have been mapped to more than one cost center.

In addition to ensuring no duplicate payments, as discussed above, time study participants must coordinate and consult with their appropriate time study reviewer/program staff to determine appropriate program-related activities.

## 5. Identify Direct Patient Care Services, Administrative Activities, and Non-Allowable Activities

The time study and activity/object codes must capture and clearly distinguish clinical or professional services that are direct patient care related from non-clinical or provider services that are administrative and other non-reimbursable activities. Because the time study must capture 100 percent of time spent *(see Principle 2, above)* for physician and non-physician practitioners, activity/object codes are designed to capture and reflect all direct patient care services and non-clinical provider administrative and non-allowable activities that may be performed, only some of which are reimbursable under SPA 05-023 and waiver.

The time study methodology must identify the costs of certain non-clinical or provider administrative services and other non-allowable activities and ensure that those costs are not included for reimbursement under SPA 05-023 and waiver. The activity codes used in the time study must distinguish among different types of activities, as well as identify whether the activities are non-allowable.

# V. PHYSICAN AND NON-PHYSICIAN PRACTITIONER COST CLAIMING METHODOLOGY

## A. Identify and Allocate Costs

Since physician and non-physician practitioners provide inpatient and outpatient services to various programs at a DPH (e.g., Medicare, Medi-Cal, Managed Care, etc.), or at government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups; the cost related to the services to the program recipients are captured on the 2552-96 Medi-Cal cost report, or in the case of the UCs, the UC “Schools of Medicine,” the costs of these activities must be identified and allocated to the various programs. This allocation of costs involves the determination and application of the proportional share of allowable component costs to the programs.

Development of the proportional program share, referred to as the physician and non-physician practitioner professional services, must be based on the approved cost finding methodology. The allocation of costs, once determined, must be included in the Workbook and the approved physician cost reporting schedule, and non-hospital cost forms, as applicable, for the purpose of establishing CPEs and receiving supplemental payments. This process is necessary to ensure that only the costs related to the programs are claimed under SPA 05-023 and waiver. The process for UC Hospitals and Non-UC hospitals is as follows:

Non-UC Hospitals

To the extent that the non-UC hospital establishes clinical or professional cost on its 2552-96 Medi-Cal cost report Worksheet A-8-2, the professional costs are:

- Limited to the allowable and auditable physician compensations that have been incurred by the hospital;

- For the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service, including sites that are not owned or operated by an affiliated government entity;

- Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment (or, for registry physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the registry physicians are contracted solely for direct patient care activities (such as, no administrative, teaching, research, or any other provider component or non-patient care activities);

- Supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above); and

- Removed from hospital costs on Worksheet A-8.

Cost may be subject to further adjustments and offsets as established by Medicare and Medicaid reimbursement principles.

Reimbursement is allowed for other professional non-practitioner service costs that have also been identified and removed from hospital costs on the Medi-Cal cost report. The practitioner types to be included for the purpose of reimbursement are Certified Registered Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Dentists, Certified Nurse Midwives, Clinical Social Workers, Clinical Psychologists, and Optometrists.

To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medi-Cal cost report, these costs may be recognized if they meet the following criteria:

- The practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medi-Cal separate from hospital services;

- For all non-physician practitioners there must be an identifiable and auditable data source by practitioner type;

- A CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs; and

- The clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the hospital does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

  The resulting net clinical non-physician practitioner compensation costs are allowable costs. The compensation costs for each non-physician practitioner type are identified separately.

Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from hospital records. Los Angeles County hospitals, due to their all-inclusive billing limitations, do not have itemized physician or non-physician practitioner charges. Therefore, these hospitals are to use the hospital RVU system to apportion professional costs to uninsured services under the SNCP claiming. This is the same RVU system as that used by Los Angeles County hospitals for Medicare and Medi-Cal cost reporting purposes. Where charges are mentioned in this paragraph and later paragraphs in this subsection, Los Angeles County will use its RVUs.

A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center by the total billed professional charges for each cost center. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type by the total billed professional charges for each practitioner type.

The total uninsured costs related to physician and non-physician practitioner professional services are determined for each cost center by multiplying total uninsured charges by the respective cost to charge ratio for the cost center. Total uninsured costs to establish CPEs for the purpose of receiving supplemental payments and establishing SNCP claiming are determined by subtracting all revenues received for the uninsured physician and/or non-physician practitioner services from the uninsured costs. In addition, costs must be reduced by 17.79 percent to account for non-emergency care furnished to undocumented persons.

UC Hospitals

The physician compensation costs are identified from each UC School of Medicine's trial balance and reported on a CMS-approved UC physician/practitioner cost report. These professional compensation costs are:

- Limited to identifiable and auditable costs that have been incurred by the UC School of Medicines' physician practice group(s) for the professional patient care furnished in all applicable sites of service, including services rendered at non-hospital physician office sites operated by the UC practice groups and at sites not owned or operated by the UC for which the UC practice group bills for and collects payment.

- Reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

On the UC physician cost report, these physician compensation costs net of National Institute of Health grants as applicable, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study. Prior to July 1, 2008, the UCs may use a CMS-approved benchmark RVU methodology in lieu of the CMS-approved time study to allocate UC physician compensation costs between clinical and non-clinical activities only. The result of the CMS-approved time study (or the benchmark RVU methodology before July 1, 2008) is the physician compensation costs pertaining only to clinical, patient care activities.

The physician clinical costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for uninsured professional cost determination purposes. There will be offset of revenues received for services furnished by such professionals to non-patients (patients for whom the UC does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

Reimbursement for non-physician practitioner compensation costs will also be included. The practitioner types to be included on the UC physician/practitioner cost reports are Certified Registered Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Dentists, Certified Nurse Midwives, Clinical Social Workers, Clinical Psychologists, and Optometrists.

These non-physician practitioner compensation costs are recognized if they meet the following criteria:

- The practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medi-Cal separate from hospital services.

- The non-physician practitioner compensation costs are derived from an identifiable and auditable data source by practitioner type.

- A CMS-approved time study will be employed to allocate practitioner compensation between clinical and non-clinical costs.

- The clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the UC does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs. Each non-physician practitioner type is reported in its own cost center on the UC physician/practitioner cost report.

The above physician or non-physician practitioner compensation costs must not be duplicative of any costs claimed on the UC hospital cost reports.

Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipments used in the furnishing of direct patient care.

Overhead costs will be recognized through the application of each UC's cognizant agency-approved rate for indirect costs. The indirect cost rate will be applied to the total direct cost, calculated above, based on each center/department's physician and/or non-physician practitioner compensation costs determined to be eligible for Medicaid reimbursement and identifiable medical supply/equipment costs to arrive at total allowable costs for each cost center.

Other than the direct costs defined above and the application of an approved indirect rate, no other costs are allowed.

Total billed professional charges by cost center related to physician services are identified from provider records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from provider records.

A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center by the total billed professional charges for each cost center. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner by the total billed professional charges for each practitioner type.

The total professional charges for each cost center related to eligible uninsured physician services, billed directly by UC, are identified using auditable UC financial records. UCs must map the claims to their cost centers using

information from their billing systems. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed 2552-96 Medi-Cal cost report.

For each non-physician practitioner type, the eligible uninsured professional charges, billed directly by the UC, are identified using auditable UC financial records. UCs must map the claims to non-physician practitioner type using information from their billing systems. Each charge must only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed 2552-96 Medi-Cal cost report.

The total uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total uninsured charges by the respective cost to charge ratio for the cost center. For each non-physician practitioner type, the total uninsured costs related to non-physician practitioner professional services are determined by multiplying total uninsured charges by the respective cost to charge ratios.

The total uninsured costs eligible for SNCP claiming are determined by subtracting all revenues received for uninsured physician practitioner services from the uninsured costs. The amount of the SNCP interim payment will be based on the costs for the period coinciding with the latest as-filed 2552-96 Medi-Cal cost report and the data sources for uninsured claims are from the auditable UC records. All revenues received (other than the SNCP professional payments being computed here in this section) for the uninsured professional services will be offset against the computed cost; these revenues include payments from or on behalf of patients and payments from other payers. The total SNCP certifiable expenditures as computed above should be reduced by 17.79 percent to account for non-emergency care furnished to undocumented persons. The costs of non-emergency care furnished to undocumented persons are eligible for federal matching funds under the DSH program only.

The following pertains to both Non-UC and UC Hospitals:

The uninsured physician/practitioner cost computed can be trended to current year based on Market Basket update factor(s) or other medical care-related indices, as approved by CMS. Theses costs may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

- Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.

- Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the hospital and subject to review by DHCS and CMS. The result is the uninsured physician/practitioner costs to be used for interim SNCP payment purposes.

## B. Support Allocated Costs by Approved Time Study

Because a time study must capture all activities that are specific to the participants' duties, activity/object codes must provide a complete and appropriate description of all activities and facilitate capturing 100 percent of the participants' time spent.

### 1. Activity/Object Codes

The following activity codes will be used to capture time spent for physician and non-physician practitioners claiming certified public expenditures (CPE) under SPA 05-023 and the waiver. Physician and non-physician practitioners that provide services at a DPH and/or at a facility for which a DPH is claiming CPE under SPA 05-023 and the waiver must complete a DHCS physician or non-physician practitioner time study, as applicable (see Appendices A-C) by documenting time spent on each of the following coded activities.

**Activity/Object Code 00001** Direct Patient Care Services

Direct Patient Care Services are allowable activities that would be considered ***professional*** component costs under Medicare cost principles. Unreimbursed Direct Patient Care Medi-Cal services to Medi-Cal recipients would be eligible for payment under SPA 05-023, and unreimbursed Direct Patient Care uninsured care costs would be eligible for payment under the waiver as SNCP Physician/Practitioner CPEs.

**Activity/Object Code 00002** Supervision and Training of Nurses, Technicians, etc.

Supervision and Training of Nurses, Technicians, etc., are allowable activities that would be includable as ***provider*** component costs under Medicare cost principles. Unreimbursed Medi-Cal services costs would be eligible to be claimed as hospital

CPEs. Unreimbursed uninsured care costs would be eligible for payment as waiver SNCP or DSH Hospital CPEs.

**Activity/Object Code 00003** Utilization Review and Other Committee Meetings

Utilization Review and Other Committee Meetings are allowable activities that would be includable as ***provider*** component costs under Medicare cost principles. Unreimbursed Medi-Cal services costs would be eligible to be claimed as hospital CPEs. Unreimbursed uninsured care costs would be eligible for payment as waiver SNCP or DSH Hospital CPEs.

**Activity/Object Code 00004** Quality Control, Medical Review, and Autopsies

Quality Control, Medical Review, and Autopsies are allowable activities that would be includable as ***provider*** component costs under Medicare cost principles. Unreimbursed Medi-Cal services costs would be eligible to be claimed as hospital CPEs. Unreimbursed uninsured care costs would be eligible for payment as waiver SNCP or DSH Hospital CPEs.

**Activity/Object Code 00005** Supervision of Interns and Residents – Physician Only

Supervision of Interns and Residents – Physician Only are allowable activities that would be includable as ***provider*** component costs under Medicare cost principles. Unreimbursed Medi-Cal services costs would be eligible to be claimed as hospital CPEs. Unreimbursed uninsured care costs would be eligible for payment as waiver SNCP or DSH Hospital CPEs.

**Activity/Object Code 00006** Teaching of Interns and Resident – Physicians Only

Teaching of Interns and Resident – Physicians Only are allowable activities that would be includable as ***provider*** component costs under Medicare cost principles. Unreimbursed Medi-Cal services cost would be eligible to be claimed as hospital CPEs. Unreimbursed uninsured care costs would be eligible for payment as SNCP or DSH Hospital CPEs.

**Activity/Object Code 00007** Teaching and Supervision of Allied Health Professionals – Physician Only

Teaching and Supervision of Allied Health Professionals – Physician Only are allowable activities that would be includable as ***provider*** component costs under Medicare cost principles. Unreimbursed Medi-Cal services cost would be eligible to be claimed as hospital CPEs. Unreimbursed uninsured care costs would be eligible for payment as SNCP or DSH Hospital CPEs.

**Activity/Object Code 00008** Other Administrative or Teaching

Other Administrative or Teaching are allowable activities that would be includable as ***provider*** component costs under Medicare cost principles. Unreimbursed Medi-Cal services cost would be eligible to be claimed as hospital CPEs. Unreimbursed uninsured care costs would be eligible for payment as SNCP or DSH Hospital CPEs.

**Activity/Object Code 00009** Conferences and Lectures

Conferences and Lectures are allocable activities under Medicare cost principles. Such costs will be proportionately allocated to all other activities, including professional component activities, provider component activities, and non-reimbursable activities.

The allocated ***professional*** component costs as they relate to Medi-Cal recipients would be eligible for payment under SPA 05-023. The allocated professional component costs as they relate to the uninsured would be eligible for payment under the waiver as SNCP Physician/Practitioner CPEs.

The allocated ***provider*** component costs as they relate to Medi-Cal recipients would be eligible to be claimed as hospital CPEs. The allocated provider component costs as they relate to the uninsured would be eligible for payment as SNCP or DSH Hospital CPEs.

**Activity/Object Code 00010** Non-Productive Hours – Paid Sick Leave, Paid Vacations, etc.

Non-Productive Hours – Paid Sick Leave, Paid Vacations, etc. are allocable costs under Medicare cost principles. Such costs will

be proportionately allocated to all other activities, including professional component activities, provider component activities, and non-reimbursable activities.

The allocated ***professional*** component costs as they relate to Medi-Cal recipients would be eligible for payment under SPA 05-023. The allocated professional component costs as they relate to the uninsured would be eligible for payment under the waiver as SNCP Physician/Practitioner CPEs.

The allocated ***provider*** component costs as they relate to Medi-Cal recipients would be eligible to be claimed as hospital CPEs. The allocated provider component costs as they relate to the uninsured would be eligible for payment as SNCP or DSH Hospital CPEs.

**Activity/Object Code 00011** Research (Non-Reimbursable)

Research – Non-Reimbursable is not allowable or allocable. This activity would be treated as non-reimbursable under Medicare cost principles.

**Activity/Object Code 00012** Other Non-Billable Activities

Other Nonbillable Activities is intended to capture all other time which the respondent does not believe is described by the other categories. Use of this category requires a description. To the extent such description of time does not fall within any of the allowable categories, the time will be non-reimbursable. An example would be consulting or other review activities that, while compensated by the entity (e.g., UC), either pertains to or is chargeable to an outside entity.

## 2. Activity/Object Code Descriptions

Major categories for the activity/object codes break down into four specific areas: Direct Patient Care Services, Hospital Administration and Teaching Services, Other Administrative and General, and Other Non-Billable Activities. Activity/Object Code descriptions are a follows:

Direct Patient Care Services

Direct patient care services are those services that would give rise to a separate physician bill in a private practice, and involve activities that are identifiable, medical services.

**Activity/Object Code 00001 -- Direct Patient Care Services**

Direct patient care is the care which is medically reasonable, necessary and ordinarily furnished (absent research programs) in the treatment of patients by physicians and providers under the supervision of physicians as indicated by the medical condition of the patients. Also, this definition intends that the appropriate level of care criteria must be met for the costs of this care to be reimbursable. Such care is represented by items and services (routine and ancillary) which may be diagnostic, therapeutic, rehabilitative, medical, psychiatric, skilled nursing, and other related professional health services.

- Use this code when performing duties and providing services which include diagnosis, treatment, therapeutic, rehabilitative, medical, psychiatric, etc.

- These direct patient care duties may occur in a teaching or non-teaching setting.

- Distinguish between teaching rounds (where the primary purpose is teaching and the clinical care is incidental) and clinical rounds (where the primary purpose is patient care and teaching is a by product of the activity.

- Clinical research conducted in conjunction with, and a part of, caring for patients is also considered patient care services if the services are considered usual patient care, and are not compensated through research funds.

- Routine services that would be provided absent a clinical trial, services required solely for the provision of the investigation item or service, and services needed for reasonable and necessary care for complications resulting from the clinical trial should be included in the Activity/Object Code.

Hospital Administration and Teaching Services

Generally these are services for which no patient bill is prepared or sent. These are usually activities which directly deal with the operation of the hospital and affect its operating efficiency.

**Activity/Object Code 00002 -- Supervision and Training of Nurses, Technicians, etc.**

- Use this code for the supervision and training of nurses, technicians, and other hospital staff, etc. in a setting that does not involve any of the approved medical education programs.

- In addition to supervision and training, activities for this code include review of care related to a specific patient, hospital or departmental administration, involving supervision of hospital employees.

**Activity/Object Code 00003 -- Utilization Review and Other Committee Meetings**

Use this code when performing utilization review, participating on committees, or attending meetings. Activities include:

- Meeting preparation and attendance for hospital, medical staff, and departmental meetings.

- Preparation and attendance at tumor boards and peer reviews.

**Activity/Object Code 00004 -- Quality Control, Medical Review, and Autopsies**

Use this code when performing quality control review or quality control investigation, or autopsies. Activities include:

- Participating individually or as a panel or board member in: quality assurance functions, informal and formal investigation, and medical review functions related to quality improvement.

- Autopsies performed at a physician's request, to advance the knowledge base regarding the patient.

**Activity/Object Code 5 -- Supervision of Interns and Residents – Physician Only**

Use this code when performing duties related to the direct supervision of Interns/Residents. Activities include:

- Providing teaching and guidance during rounds, review with Interns/Residents regarding individual patient care.

- Time spent managing, planning, and evaluating the work of Interns/Residents.

Note: This activity code does not include direct patient care.

**Activity/Object Code 6 -- Teaching of Interns and Resident – Physicians Only**

Use this code when performing duties related to teaching Intern/Residents. Activities include:

- Teaching in an approved educational program in a classroom, lecture hall, formal or subject appropriate setting.
- Preparation of materials and time spent preparing materials and subject matter for presentation.

**Activity/Object Code 7 -- Teaching and Supervision of Allied Health Professionals – Physician Only**

Use this code when performing duties related to the teaching and/or supervision of Allied Health Professionals. Activities include:

- Teaching in an approved educational program in a classroom, lecture hall, formal or subject matter appropriate setting.
- Preparation of materials and time spent preparing materials and subject matter for presentation.
- Supervision of Allied Health Professionals performing procedures related to specific patients.

**Activity/Object Code 8 -- Other Administrative or Teaching**

Use this code to include other time spent, as appropriate, related to other administrative or teaching functions. Activities must be fully described and explained, and should not be applicable to other teaching activity/object codes.

**Activity/Object Code 9 -- Conferences and Lectures**

Use this code when attending conferences and lectures, or similar education forums including continuing medical education classes. Activities include:

- Travel and attendance either as a presenter or attendee, planning, and preparation.
- Attendance at lectures or similar education forums, including continuing medical education classes and workshops to maintain active licensure status if done during compensation time.

**Activity/Object Code 10 -- Non-Productive Hours – Paid Sick Leave, Paid Vacations, etc.**

Self-Explanatory.

**Activity/Object Code 11 -- Research (Non-Reimbursable)**

Use this code for non-patient related activities which include:

- Research performed for scientific knowledge, planning, preparation of research materials and reports.
- Research involving a systematic, extensive study directed at better scientific knowledge of the science and diagnosis, treatment, cure, or prevention of mental or physical disease.
- Usually obtained in the laboratory or on chart review, and does not necessarily involve direct individual or collective patient care.
- To the extent that this activity is not done on hospital/facility time, (hospital/facility time includes time applicable to a Medical School Operating or Professional Services Agreement and other contracts,) this time should be excluded from your time study report.

**Activity/Object Code 12 -- Other Non-Billable Activities**

Use this code for other non-patient care related activities that are compensated by the hospital/County/UC; are not specified under other activity/object codes and would not ordinarily permit or generate a bill for patient care services, e.g., consulting or medical review that is chargeable to another entity (non-hospital, non-UC, etc.).

## VI. Claiming FFP and Payment Procedures

### A. Federal Financial Participation

DPHs and the government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, must incur the expenditures for allowable costs associated with federally approved activities related to the STCs and SPA 05-023. No State General Fund will be available to support any payments. DHCS will reimburse an amount equal to FFP, at the applicable Federal Medical Assistance Percentage (FMAP) for costs established through the cost claiming process. In addition, DPHs will attest to DHCS that they expended funds totaling 100 percent of the cost they are claiming in the Workbook.

### B. Offset of Revenues

A DPH may not claim any federal reimbursements for physician and non-physician practitioner services if its total cost has already been paid by other

federal sources. A governmental program may not be reimbursed in excess of its actual costs, i.e., make a profit. Allocated costs must be offset by the amount of other funding and payment sources in order to assure there is no duplication of payment. To the extent that other funding and payment sources have paid or would pay for the costs of physician and non-physician practitioner services, federal reimbursements are not available and the costs must be removed from the total reported costs. The following are some of the funding categories that must be offset against unallowable costs:

- All payments for services related to "non-authorized" federal funds.
- All expenditures that have previously been reimbursed by the Federal Government with federal funds.
- All additional payments or offsets identified as applicable under the STCs and SPA 05-023.

## C. Timely Filing Requirements for Claiming FFP

The State must file claims for FFP within a two-year period that begins on the first day of the calendar quarter immediately following the quarter in which the expenditure was made. The implementing regulations for timely filing are at *Subpart A of Title 45 of the Code of Federal Regulations (45 CFR)* and provide specific guidelines for determining when expenditure is made, so as to initiate the two-year filing period. Federal regulations at *Section 95.13(d) of 45 CFR* indicate that a state agency's expenditure for administration is considered to have been made in the quarter the payment was actually made by the state agency.

Further, *Section 95.4* of *45 CFR* identifies a state agency as any agency of the state, including the state Medicaid agency, its fiscal agents, a state health agency, or any other state or local organization which incurs reimbursable expenses.

> *Example: A hospital incurs reimbursable expenditures in January 2006. The end of the calendar quarter in which the expenditure occurs is March 31, 2006. In order to meet the two-year filing limit timely, the state Medicaid agency must file a claim with CMS within two years after the calendar quarter in which the expenditure occurred, or by March 31, 2008.*

In determining the two-year filing limit, DHCS must give consideration to the expenditure reporting cycle. The expenditure is not considered claimed until it is reported to CMS on the CMS-64 Expenditure Report, which is required to be filed with CMS 30 days after the end of a reporting quarter.

## D. Supporting Documentation

DPHs must maintain records and be able to support the claims against the SNCP for physician and non-physician practitioner services. DPHs are responsible for

the proper documentation of all costs claimed under SPA 05-023 and waiver, and are subject to review by DHCS and CMS. In addition to completed time studies, documentation may include, but is not limited to:

- Support for salaries and wages, including personnel activity reports/schedules.
- Verified accounting records that support costs and charges.
- Utilization statistics or RVUs to establish program allocations.

## VII. Time Study Training and Implementation

### A. Time Study Training

All physician and non-physician practitioners whose costs are claimed on the Workbook must complete the required time study. Physician and non-physician practitioners must receive adequate training before participating in their first time study. Time study participants are expected to provide signed documentation as evidence of such training. Attendance at the time study training session *cannot* be claimed during any study week by the time study participants. The training will teach participants how to complete the time study form, how to report activities under the appropriate time study codes, the difference between direct patient care services, hospital administration and teaching services, and non-allowable activities, and where to obtain technical assistance, if needed.

The DPHs must have a mechanism in place to assess how often training is necessary and to revise the training schedule, if appropriate. To ensure consistent application, all training documentation must be maintained and available for audit purposes. Documentation must show the content of the training provided to participating physician and non-physician practitioners and the frequency of training. The frequency of training should take into account staff turnover and the need for additional training.

Each DPH will designate a minimum of one representative to receive training from DHCS prior to the DPH participating in the first time study. This representative will be responsible for providing training at their respective DPH and the government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups for time study participation and completion. DHCS will provide technical assistance to the DPH representative on an as needed basis.

### B. Time Study Sampling and Participation

The time study sampling process is approved for use in California as meeting the requirements for statistically valid as agreed upon between DHCS and CMS, and requires an assured randomized time period with a large enough sample of physician and non-physician practitioners to ensure that the time survey is

statistically valid at the 95 percent or higher confidence level for a 5 percent error level. DHCS will ensure the compliance of the DPHs and their government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, by performing a review of time study documentation for physician and non-physician practitioner services claimed under SPA 05-023 and waiver:

- A time study shall be conducted for each DPH and their government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, for one week of every quarter. The random number generator function used to select the specific week uses a Microsoft and industry programming standard for generating computerized random numbers in computer code for each time-study quarter. The weeklong time study shall be randomly selected by DHCS and accepted as representative of the DPH for that quarter. A period of time, longer than a week, may be determined to be necessary for the time study to ensure that the time survey is statistically valid.

- Every physician and non-physician practitioner providing services at the DPH, and the government-operated entities with which the DPH is affiliated, including their affiliated government-operated physician practice groups, capturing activities through the time study, and reporting physician and non-physician practitioner costs on their hospital's respective Workbook, shall complete and sign a record of the actual activities engaged in by that physician or non-physician practitioner for all paid time throughout the work day during the period of the time study, by means of the detailed time study form developed by DHCS, and approved by CMS. The time study shall record all activities, and shall document time spent, resulting in the capture of 100 percent of each physician or non-physician practitioner's activities.

- The signed time study form shall include, at minimum: 1) the name of the physician or non-physician practitioner completing the time study and performing the allowable activities; 2) the physician or non-physician practitioner's department, job classification/position; 3) the state fiscal year quarter, and dates covered by the time study; 4) the activity/object code applicable to the time spent during the work day; and 5) a written description of the activity itself, if applicable; and signature of a supervisor/reviewer confirming that the time study form accurately represents the action and services performed by the physician or non-physician practitioner. Appendices A-C display the approved and required time study forms. Time studies that do not meet the above standards may not be used for claiming CPE in the DPHs' respective Workbook.

For the purpose of establishing the time study duration and sample size criteria needed to satisfy the requirements for obtaining statistical validity at the 95

percent or higher confidence level for a 5 percent error level, when sampling is performed at the DPHs, the following is established:

- UC – Physicians: Physicians for all specialties and cost centers at the UC DPHs and the government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, total 4,255. For the purpose of the time study, UC Physicians will account for 100 percent of their time using the approved time study form, and will not be sampled. Costs pertaining to these physicians will be allocated based on the actual time determined to be allowable/allocable. It is the intent of the UCs, that physicians not be part of the sampling process in order to sufficiently capture and document time spent.

- UC Non-Physician Practitioners: UC Non-Physician Practitioners for all specialties and cost centers at the UC DPHs and the government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, total 904. For the purpose of the time study, UC Non-Physician Practitioners will account for 100 percent of their time using the approved time study form, and will not be sampled. Costs pertaining to these non-physician practitioners will be allocated based on the actual time determined to be allowable/allocable. It is the intent of the UCs, that Non-Physician Practitioners not be part of the sampling process in order to sufficiently capture and document time spent.

- Non-UC Non-Physician Practitioners: Non-UC Non-Physician Practitioners for all specialties and cost centers at the Other Government-Operated Hospitals and Non-State Government-Operated Hospitals, and the government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, total 375.

## C. Time Study Conditions/Exceptions

1. DHCS will randomly select the week of the time study period each quarter. DPH representatives will be notified of the selected time study dates 30 days prior to the beginning of the time study week. DHCS will notify time study participants no more than 5 days prior to the actual time study period and the time study form must be submitted 5 days after the time study is completed. The time study represents a sample of services and work which is used to determine the physician and non-physician practitioner costs reported on the Workbook. Time study participants must complete the time study form within the time study period that is randomly selected by DHCS.

   A one-week time study typically means studying five consecutive paid work days (skipping unpaid work days), starting on a randomly selected day in a quarter. Should a work interruption occur during the course of the

time study (such as a natural disaster), which prevents the participants from completing the time study for five consecutive paid work days, the time study will resume on the first feasible paid work day and continue thereafter until the consecutive five paid work days requirement is met. For example, in a randomly selected time study week of Monday through Friday, if a time study was conducted on Monday and Tuesday of that week, and a disaster occurred on Wednesday through the rest of that week, two consecutive days would have been time studied for that week. The time study should resume from the next feasible paid work day for three consecutive days to meet the five consecutive paid work days' requirement. If another event causes a stoppage or results in an interruption/break in between the remaining consecutive days, the remaining time study would start from the next feasible paid work day until the five consecutive paid work days are completed. In this case, the only break/s of the required five consecutive paid work week would be the disaster days.

2. The DPH, and their government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, will randomly select a 10 percent sample of coded responses which will be submitted to DHCS each quarter for validation. The validation will consist of reviewing the participant responses and the corresponding code assigned to determine if the code was accurate. DHCS will review the results and independently code the activity and compare it to the activity recorded by the coder. DHCS will require the DPH, and their government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups to submit a corrective action plan if there is a variance.

3. If the response rate of the time studies submitted from the physician or non-physician practitioners at a DPH, and their government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, is 85 percent or higher, the time studies not submitted from the remaining physician and non-physician practitioners may be excluded from the calculation of time study results.

4. If the time study response rate is less than 85 percent of the physician and non-physician practitioners at a DPH, and their government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, CMS and DHCS will review the reasons for the non-response and determine how the total cost associated with those physician and non-physician practitioners who did not submit time studies will be determined.

5. Payments made to the DPHs as a result of the time study, and the associated costs reported on the DPHs are subject to review through the

Interim Reconciliation and Final Reconciliation process as established in Attachment F of the STCs.

## D. Assistance, Oversight, and Monitoring

In order to ensure that the time study is statistically valid as specified in Section VII. B., DHCS will provide assistance to clarify the CMS-approved sampling methodology to be applied. DHCS will monitor the DPHs' sampling and time study participation and response rates to ensure that DPHs adhere to statistical sampling criteria.

Should DHCS identify that approved time study and time study methodology has not been properly implemented by a DPH, DHCS will perform on-site monitoring to evaluate a DPH, and their government-operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, to ensure accurate CPE reporting and claiming.