II. REIMBURSEMENT LIMITS

A. Reimbursement for in-state hospital inpatient services provided to Medi-Cal program beneficiaries for provider fiscal periods beginning on or after May 23, 1992 and not fully covered by a negotiated contract as allowed in the Welfare and Institution Code (W&I) Section 14081, shall be the lowest of the following four items except as stated in B., D., F., G., H., M., and N., for each provider:

1) Customary charges;

2) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 Code of Federal Regulations (CFR), Part 413 and HCFA Publication 15-1.

3) All-inclusive rate per discharge limitation (ARPDL). This is detailed in Section V. of this Plan.

4) The peer grouping rate per discharge limitation (PGRPDL). This is detailed in Section IX. of this Plan.

B. The following adjustment should be made to items 1) through 4) above:

1) Providers shall also be reimbursed for disproportionate share payments if applicable.

2) The least of the four items listed in A. 1) – 4) above shall be reduced by the amount of TPL.

C. Amounts determined under 3) or 4) above may be increased only by an AA or formal appeal.

D. New hospitals and rural hospitals shall be exempt from the provisions of this part of the Plan relating to the MIRL and PIRL. New and rural hospitals shall be reimbursed in accordance with the lessor of A. 1) or A. 2) above, and subject to any limitations provided for under federal law and/or regulation.

E. Reimbursement for hospital inpatient services provided by State Hospitals under the jurisdiction of the State Department of Developmental Services and Mental Health will be exempt from Section I. through XVI. of this Plan. Payment for services to these providers will be under Medicare retrospective reimbursement principles; audit, administrative and appeal procedures; and applicable cost ceiling limitations.

F. Each provider shall be notified of the ARPDL and PGRPDL at the time of tentative and/or final PIRL settlements. If only a final PIRL settlement is issued, it shall take the place of both the tentative and final PIRL settlement.

G. Payments for Medicare covered services provided to Medicare/Medi-Cal crossover patients shall not be subject to the limitations specified in this part of the Plan. These services shall be reimbursed only for the Medicare deductibles and co-insurance amounts. The deductibles and co-insurance amounts shall not exceed the state reimbursement maximums. State reimbursement maximums shall be the interim rate times Medi-Cal charges after consideration of the Medicare payment.

H. Payment for skilled nursing facility services shall be made in accordance with Section 51511.

I. Payment for intermediate care facility services shall be made in accordance with Section 51510.

J. Hospitals that elect to provide transitional inpatient care services by voluntarily entering into a transitional inpatient care contract will receive a reimbursement rate that is modeled on the distinct-part nursing facility reimbursement rates, and includes increases for components of the transitional inpatient care program that are not part of the distinct-part nursing facility rate. (For details about the payment methodology, refer to Supplement 2 to Attachment 4.19D for the "Study to Determine Rates for Transitional Inpatient Care".)

K. Hospitals that do not elect to voluntarily enter into a transitional inpatient care contract, but are located in a geographic area where a transitional inpatient care contractor(s) exists, may transfer a TC patient to a contract facility. Until the patient is transferred, the hospital will be reimbursed in the same manner and at the same rate as a hospital that has voluntarily entered into a transitional inpatient care contract. This rate is higher than that paid for nursing facility services alone, but lower than the acute inpatient hospital rate.

L. 1) Allowable costs, as that term is used in Section II.A.2, and elsewhere in this Attachment 4.19-A, shall not include provider expenditures to assist, promote,or deter union organizing to the extent such expenditures are paid by the provider with State funds. Definitions applicable to this paragraph L are set forth below in subparagraphs 2) and 3).

2) "Assist, promote, or deter union organizing" means any attempt by the provider to influence the decision of its employees in California, or the California employees of its subcontractors, regarding either of the following:

(a) Whether to support or oppose a labor organization that represents or seeks to represent employees.

(b) Whether to become a member of any labor organization.

3) "State funds" means California State Treasury funds or California State special or trust funds received by the provider on account of the provider's participation in a California state program. If State funds and other funds are commingled, any expenditures to assist, promote, or deter union organizing shall be allocated between State funds and other funds on a pro rata basis.

4) Any costs, including legal and consulting fees and salaries of supervisors and employees, incurred for research for, or preparation, planning, or coordination of, or carrying out, an activity to assist, promote, or deter union organizing shall be treated as paid or incurred for that activity.

5) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(a) Addressing a grievance or negotiating or administering a collective bargaining agreement.

(b) Allowing a labor organization or its representatives access to the provider's facilities or property.

(c) Performing an activity required by federal or state law or by a collective bargaining agreement.

(d) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

M. Noncontract Hospital Inpatient Services: Effective July 1, 2008

(1) In determining reimbursement for a final cost report settlement for a hospital's fiscal period that includes any dates of service on or after July 1, 2008, the reimbursement limitation under paragraph II.A.2 for services on or after that date, shall be 90 percent of the allowable cost per day determined under that paragraph, multiplied by the number of Medi-Cal covered inpatient days on or after July 1, 2008, within the hospital's fiscal period.

(2) The payment limitation provided in paragraph (1) above applies to small and rural hospitals, as defined in Section 124840 of the California Health and Safety Code as of July 1, 2008, for dates of service July 1, 2008, through and including October 31, 2008. For dates of service on or after July 1, 2009, small and rural hospitals will be subject to the payment limitation in subparagraph (1) above.

(3) Hospitals that are certified by Medicare as Medical Critical Access Providers or as Rural Referral Centers are exempt from the payment reductions described in subparagraph (2) for dates of service on and after July 1, 2009.

N. Noncontract Hospital Inpatient Services: Effective October 1, 2008

(1) In determining reimbursement for a final cost report settlement for a hospital's fiscal period that includes dates of service on or after October 1, 2008, the reimbursement limitation under paragraph II.A.2 for inpatient services on or after that date applicable to hospitals not under contract with the California Medical Assistance Commission (CMAC) will not exceed either the limit set forth in paragraph M or the applicable regional average per diem CMAC contract rate for tertiary and other hospitals, reduced by five percent.

(2) Paragraph N(1) does not apply to either of the following:

(i) Small and rural hospitals pursuant to California Health and Safety Code section 124840 as of July 1, 2008.

(ii) Hospitals with licensed general acute care beds located in open health facility planning areas on October 1, 2008, unless the open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area, or the open health facility planning area has three or

more hospitals that are not state-owned with licensed general acute care beds.

(3) The applicable CMAC regional average per diem contract rate, as set forth in paragraph N(1), will be derived from the unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in CMAC's Annual Report to the California Legislature (Annual Report). For tertiary hospitals and for all other hospitals, the regional average per diem contract rates will be based on the geographic regions in CMAC's Annual Report. These rates were published by the Department on or before October 1, 2008, and will be updated annually for each state fiscal year and become effective on the following July 1. Supplemental payments will not be included in this calculation.

(4) The federal and non-federal share of designated public hospital cost-based rates will be included in the determination of the average contract rates by including the total allowable costs that are used for the calculation of the hospital's interim rate that is in effect on June 1 of each year, pursuant to California Welfare and Institutions Code section 14166.4 as of October 5, 2005.

(5) The applicable average per diem contract rates are published annually by the Department, and these rates will be updated annually for each state fiscal year and become effective each July 1, thereafter.

(6) For purposes of this paragraph N, the following definitions apply:

(i) "Tertiary hospital" means a children's hospital as defined in California Welfare and Institutions Code section 10727 as of June 1, 1996, or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Title 22 of the California Code of Regulations sections 100259 – 100260 as of August 12, 1999.

(ii) "Open health facility planning area" (or "open area") and "closed health facility planning area" (or "closed area") have the same meanings and will be applied in the same manner as used by CMAC in the implementation of the hospital

contracting program authorized in California Welfare and Institutions Code sections 14081 et. seq. as of July 1, 2008.

"Open areas" are those health facility planning areas where there are no or insufficient SPCP contracting hospitals to provide Medi-Cal inpatient services. A Medi-Cal beneficiary may receive inpatient services in any hospital in an open area. The California Medical Assistance Commission determines whether a health facility planning area is open or closed.

"Closed areas" are those health facility planning areas where: (1) SPCP contracts for sufficient beds for required services have been negotiated; (2) Medi-Cal beneficiaries must receive inpatient services at a contract hospital, and (3) emergency services may be provided in a non-contract hospital only until the patient is stabilized for transfer to a SPCP contract hospital under Welfare and Institutions Code section 14087 as of July 1, 2008 in order to direct inpatient services to SPCP contracting hospitals.

III. METHODS OF PAYMENT

A. The methods of payment for inpatient hospital services under the MIRL shall include the following:

1) An ARPD that shall be retrospectively established for each provider's tentative and final settlement fiscal period. The ARPD shall:

(a) Apply to all non-contract Medi-Cal inpatient covered services provided by the provider during its settlement fiscal period. It shall be based upon the statistics included in the providers Medi-Cal cost or audit report.

(b) Be updated annually to reflect reimbursable changes in factor input prices, service intensity, technology, productivity, patient volume, and other items as allowed through the AA and appeals process.

2) An interim payment rate based upon an actual or projected reimbursable cost to charge ratio.

(a) The current interim payment rate shall be based on the lower of the following:

1. The latest tentative settlement fiscal period for which a final settlement has not been issued.

2. The latest final (which also includes recalculated finals) settlement fiscal period reimbursable cost-to-allowable customary charge ratio expressed as a percentage, rounded to the nearest whole integer, up or down.

(b) Interim payment rates calculated under A. may use data from settlements that have been previously issued if needed to determine the lower of 1) and 2) above.

(c) When newly-established providers do not have cost experience which to base a determination of an interim rate of payment the Department will use the following methods to determine an appropriate rate:

1. If there is a provider or providers comparable in substantially all relevant factors to the

provider for which the rate is needed, the Department will base an interim rate of payment on the reimbursable costs and customary charges of the comparable provider.

2. If there are no substantially comparable providers from whom data are available, the Department will determine an interim rate of payment based on the budgeted or projected reimbursable costs and customary charges of the provider.

3. Under either method, the Department will review the provider's cost and charge experience and adjust the interim rate of payment in line with the provider's cost and charge experience.

4. The Department may prohibit increases in the accommodation rates, as defined in applicable parts of 42 CFR, Part 413 and HCFA Publication 15 – 1, charged by the provider if the Department projects that such increases would cause their interim payments to exceed the PIRL.

5. Newly established providers may appeal their interim rate if it is based upon the criteria in A. 2) (c) 1. through 4, in accordance with the AAR procedures specified in Section VI. of this Plan.

(d) For dates of service on or after July 1, 2008, interim payments that would otherwise be made based on the interim rate established in accordance with this paragraph will be reduced by ten percent. Hospitals that are certified by Medicare as Medical Critical Access Providers or as Rural Referral Centers are exempt from the payment reductions for dates of service on or after November 1, 2008 as specified in this paragraph (d). Other small and rural hospitals are exempt from the payment reduction during the period November 1, 2008 through June 30, 2009.

(e)(1) Notwithstanding paragraph (d), for dates of service on or after October 1, 2008, interim payments that would otherwise be made based on the interim rate established in accordance with this paragraph III for inpatient hospital services will not exceed the applicable regional average per diem California Medical Assistance Commission (CMAC) contract rate for tertiary and other hospitals, reduced by five percent.

(2) For purposes of this paragraph (e), the term "tertiary hospital" means as defined in paragraph II.N(6), above.

(3) Paragraph (e)(1) does not apply to either of the following:

(i) Small and rural hospitals, as defined in California Health and Safety Code section 124840 as of July 1, 2008.

(ii) Hospitals with licensed general acute care beds located in open health facility planning areas on October 1, 2008, unless the open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area, or the open health facility planning area has three or more hospitals (that are not state-owned) with licensed general acute care beds. As used in this subparagraph, the terms "open health facility planning area" and "closed health facility planning area" have the same meanings as defined in Paragraph II.N(6), above.

(4) The applicable CMAC regional average per diem contract rate will be derived from the unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in CMAC's Annual Report to the Legislature (Annual Report). For tertiary hospitals and for all other hospitals, the regional average per diem contract rates will be based on the geographic regions in CMAC's Annual Report. These rates were published by the Department on or before October 1, 2008, and will be updated annually for each state fiscal year and become effective on the following July 1. Supplemental payments will not be included in this calculation.

(5) The federal and non-federal share of designated public hospital cost-based rates will be included in the determination of the average contract rates by including the total allowable costs that are used for the calculation of the hospital's interim rate that is in effect on June 1 of each year, established pursuant to California Welfare and Institutions Code section 14166.4 as of October 5, 2005.

(6) The applicable average per diem contract rates were published by the Department on or before October 1, 2008, and these rates will be updated annually for each state fiscal year and become effective each July 1, thereafter.

(f) The hospitals and hospital groups listed below are reimbursed at reduced payments based on the particular reductions in effect for the specified time periods. The reductions in Sections II.M, II.N, III.A.2.d, and III.A.2.e of this Attachment 4.19–A are only applied to the following hospitals for the following specified periods.

1. Non-Contract Hospitals (17 Hospitals and Hospital Groups - Santa Rosa Memorial Hospital, Petaluma Valley Hospital, Queen Of The Valley Hospital - Napa, St. Helena Hospital, John Muir Medical Center, Central Valley General Hospital, San Joaquin Community Hospital, Bakersfield Heart Hospital, Lancaster Community Hospital, AHMC Anaheim Regional Medical Center, LP (Anaheim Memorial Medical Center), Orange Coast Memorial Medical Center, Fountain Valley Regional Hospital Medical Center, Hoag Memorial Hospital Presbyterian, Mission Hospital Regional Med Center, Saddleback Memorial Med Center - Laguna Hills, Children's Hospital At Mission, and San Antonio Community Hospital)

Period in Effect	Reduction Type	Description of the Reductions
07/01/08 - 09/30/08	10%	The hospitals and hospital groups identified above are subject to the ten percent payment reduction.
10/01/08 - 04/05/09	10%; limit at average CMAC rate minus 5%	The hospitals and hospital groups identified above are subject to the CMAC minus five percent rate reduction, until 4/5/2009.
04/06/09 - 11/17/09	10%	The hospitals and hospital groups identified above are subject to the ten percent payment reduction until 11/17/2009.
01/01/11 - 04/12/11	10%; limit at average CMAC rate minus 5%	SB 90 (2011) ended the hospital inpatient payment reductions effective 4/13/2011.

2. Non-Contract Hospitals (Other than the hospitals identified in paragraph 1 above and those hospital categories below)

Period in Effect	Reduction Type	Description of the Reductions
07/01/08 - 09/30/08	10%	All non-contract hospitals are subject to the ten percent payment reduction.
10/01/08-04/05/09	10%; limit at average CMAC rate minus 5%	All non-contract hospitals in closed Health Facility Planning Areas (HFPAs) and non-contract hospitals in open HFPAs with at least 3 hospitals are subject to the CMAC minus five percent rate reduction, until 4/5/2009.
04/06/09 - 12/31/2010	10%	All non-contract hospitals are subject to the ten percent payment reduction.
01/01/11 - 04/12/11	10%; limit at average CMAC rate minus 5%	SB 90 (2011) ended the hospital inpatient payment reductions effective 4/13/2011.

3. Small & Rural (Critical Access Hospitals [CAHs] & Federal Rural Referral Centers [RRCs])

Period in Effect	Reduction Type	Description of the Reductions
07/01/08-10/31/08	10%	All non-contract small and rural hospitals that are Critical Access Hospitals (CAHs) and federal Rural Referral Centers (RRCs) are subject to the ten percent payment reduction.

4. Small & Rural Hospitals (non-CAHs and non-federal RRCs)

Period in Effect	Reduction Type	Description of the Reductions
07/01/08 -10/31/08	10%	All non-contract small and rural hospitals that are not Critical Access Hospitals or not federal Rural Referral Centers are subject to the ten percent payment reduction.
07/01/09 - 02/23/10	10%	All non-contract small and rural hospitals that are not Critical Access Hospitals or not federal Rural Referral Centers are subject to the ten percent payment until 2/23/2010.
1/1/11 – 4/12/11	10%	SB 90 (2011) ended the hospital inpatient payment reductions effective 4/13/2011.

5. Non-contract hospitals in an Open Health Facility Planning Area that were Open Health Facility Planning Areas on October 1, 2008, which has less than three hospitals (that are not state-owned) with licensed acute care beds, but that Open Health Facility Planning Area cannot be a Closed Health Facility Planning Area at any time on or after July 1, 2005

Period in Effect	Reduction Type	Description of the Reductions
07/01/08-04/12/11	10%	SB 90 (2011) ended the hospital inpatient payment reductions effective 4/13/2011.

(g) The payment reductions in the previous section(s) will be monitored in accordance with the monitoring plan at Attachment 4.19-F.

IV. OVERPAYMENTS

A. Interim payment rate adjustments and recovery of overpayments to providers shall be made at tentative or final settlement based upon the application of this plan.

1) Such overpayments shall be collected and such interim payment rates shall be adjusted whether or not appeals of any audit, MIRL or PIRL for the current or any prior fiscal period have been filed by the provider.

2) Interim payment rates calculated after May 23, 1992 for Sections I. through XIII. of this Plan and applied to services provided after May 23, 1992, shall comply with Sections III. and IV. of this Plan even if the actual settlement upon which the new interim rate is based, is not subject to the Plan.

B. Within the time specified in 42 CFR 433.316 - 433.320, the State will refund to HCFA the federal share of the provider overpayments, unless the overpayment debt has been discharged in bankruptcy or is otherwise uncollectable as specified in 42 USC Section 1396 b(d) (2) (D).

V. REIMBURSEMENT FORMULA

A. A hospital cost index (HCI) shall be established for each provider. This index shall consist of an input price index (IPI) and shall contain an allowance for changes in scientific and technological advancement; service intensity and productivity. The allowance shall be called the Service Intensity, Productivity, Scientific and Technological Advancement Factor (SIPTF). The HCI shall be calculated:

1) To account for actual changes in the IPI after the close of each provider's accounting period.

2) By multiplying the HCI by the non-pass-through portion of the provider's MIRL reimbursement rate per discharge (tentative or final) for the prior fiscal period to determine the non-pass-through portion of its ARPD for the settlement fiscal period.

B. The prior period shall always be the base period for each settlement.

C. For the initial base period only, the non-pass-through portion of the ARPD shall be calculated as follows:

1) Step 1, add the amount of TPL for the initial base period to the MIRL (lowest of 51536(a)(1)-(3)) which includes amounts reimbursed under the AA and appeals process for the initial base period.

2) Step 2, recalculate Medi-Cal discharges for any initial base period in accordance with the definition of Medi-Cal discharges contained in Section II. of this Plan.

(a) The Department shall notify the provider of the revised count of Medi-Cal discharges for the initial base period.

(b) The provider may file an AAR on the count of Medi-Cal discharges for the initial base period only and only as it is used in the settlement period MIRL. The AAR

must be filed within 60 days of notification of the number of Medi-Cal discharges for the initial base period.

(c) The provider may file an appeal of the Department's response to the AAR in accordance with Section VIII. of this Plan.

3) Step 3, divide the result of step 1 by the result of step 2.

4) Step 4, multiply the percentage of non-pass-through costs for the initial base period by the result of step 3.

5) Use the result of step 4 in place of the PNPARPD in the ARPD formula in D. below.

D. The ARPD shall be calculated as follows:

ARPD = PASPD + NPARPD.
= PASPD + (PNPARPD * HCI)
= (TPTC/THD) + (PNPARPD * ((AIPI * CMAF) + SIPTF))

Where ARPD = All-inclusive Rate Per Discharge.
PASPD = Pass through per discharge = TPTC/THD
TPTC = Total pass through costs in the settlement fiscal period.

THD = Total hospital discharges in the settlement fiscal period.

NPARPD = Non-Pass-through All-inclusive Rate Per Discharge.

NPARPD = PNPARPD * HCI.

PNPARPD = Prior year Non-Pass-through portion of the MIRL reimbursement rate per discharge which is, ((PMIRL - (PMCDIS * (PTPTC/PTHD)))/PMCDIS)

Where:

PMIRL = Prior fiscal period MIRL.
PMCDIS = Prior fiscal period number of Medi-Cal discharges.
PTPTC = Prior fiscal period total pass through costs.
PTHD = Prior fiscal period total hospital discharges

HCI = Hospital Cost Index =

((AIPI) ** (Days/730))* CMAF) + (SIPTF. **(Days/730))

If the prior or settlement fiscal period is long (over 370 days) or short (under 360 days). If both fiscal periods are over 359 days and under 371 days HCI = (AIPI * CMAF) + SIPTF.

Where:

AIPI = Adjusted Input Price Index.

SIPTF = Allowance for Service Intensity, Productivity, and Scientific and Technological Advancement Factor.

Days = Sum of days in the current and prior fiscal periods.

CMAF = Case mix adjustment factor.

* = Multiplication.
** = Exponentiation.

E. An annual allowance for service intensity, productivity and scientific and technological advancement shall be added to the allowable increase in the non-pass-through portion of the ARPD, as detailed in the formulas in this part of the Plan. This allowance shall be in addition to reimbursement for pass-through categories and shall be the net amount of changes for scientific and technological advancement, productivity improvement and service intensity, if any (excluding case mix), as recommended annually by the Prospective Payment Assessment Commission for the Medicare PPS for all FPEs during the PPS effective dates of the recommended allowance.

F. The pass-through categories are those hospital cost categories which, for purposes of tentative and final settlement, are not subject to the HCI.

1) Each pass-through category is listed below:

(a) Depreciation.
(b) Rents and Leases.
(c) Interest.
(d) Property Taxes and License Fees.
(e) Utility Expenses.
(f) Malpractice Insurance.

G. An IPI shall be established to compute the reimbursable change in the prices of goods and services purchased by the providers (except for pass-throughs). The IPI shall consist of a market basket classification of goods and services purchased by providers, a corresponding set of market basket weights derived from each provider's own mix of purchased goods and services, and a related series of price indicators.

H. Weights corresponding to market basket categories shall be derived and updated for each settlement fiscal period. These weights shall be computed using the latest available information from each provider's Medi-Cal cost report. If information from this source is not sufficient to establish a hospital specific weight for a particular market basket category, the Department shall assign a weight based on information from the United States National Hospital Input Price Index published by the Department of Health and Human Services, or other available sources.

I. The IPI shall be calculated after the close of each hospital's FPE, to account for actual and/or estimated changes in the:

1) Hospital specific wage and benefit rates.

(a) The index for allowable increases in wages shall be computed as follows:

Salary and Wage Index (SWI) = CLSA/ACSA.

Where:
CLSA = Summation of (PYHx * CYHRx) for all x.

ACSA = Summation of all Actual Prior Fiscal Period Salaries for all x categories.
x = The following categories:

a. Technicians and Specialists.
b. Registered Nurses.
c. LVNs.
d. Aides and orderlies.
e. Clerical and other administrative.
f. Environmental and food service.

PYHx = Prior Fiscal Period Productive Hours.

CYHRx = Current (Settlement) Fiscal Period Hourly Rate = CYSx/CYHx.

CYSx = Current (Settlement) Fiscal Period salary Expense for each category.

CYHx = Current (Settlement) Fiscal Period productive Hours.

(b) The Employee Benefits Index (EBI) shall be computed as follows:

EBI = (PYHT X CYBR)/PYB.

Where:

PYHT = Prior Year (Prior Fiscal Period) Paid Labor Hours for All Labor Categories.

CYBR = Current Year (Settlement Fiscal Period) Benefit Rate = CYB/CYHT.

PYB = Prior Year (Prior Fiscal Period) Benefits Costs.

CYB = Current Year (Settlement Fiscal Period) Benefits costs.

CYHT = Current Year (Settlement Fiscal Period) Labor Hours for All Labor Categories.

(c) The SWI and EBI shall be annualized for any provider which has a short or long (under 360 or over 370 days) prior or current fiscal period.

1. The SWI shall be adjusted using the following formula:

ASWI = SWI ** (730/Days).
ASWI = Adjusted SWI.
Where Days = Total days in the current and prior fiscal periods.

2. The EBI shall be adjusted using the following formula:

AEBI = EBI ** (730/Days).
Where:
AEBI = Adjusted EBI.
Days = Total days in the current and prior fiscal periods.

3. If the SWI and EBI are not annualized, then the ASWI = SWI and AEBI = EBI.

2) Price indicators for other non-pass-through categories.

3) Market basket weights for the following categories:
   (a) Salary and wages.
   (b) Benefits.
   (c) Professional fees, medical.
   (d) Professional fees, other.
   (e) Food.
   (f) Drugs.
   (g) All other non-pass-through costs.

4) The non-pass-through costs "all other" category shall be weighted using the following weights for purposes of calculating the price indicator:

Category	Weight
Chemicals	12.16%
Surgical and Medical Instruments and Supplies	10.59%
Rubber and Miscellaneous Plastics	9.02%
Travel	4.71%
Apparel and Textiles	4.31%
Business Services	14.90%
All other miscellaneous	44.31%

5) The weights for the seven market basket categories shall be the percentage of costs for each category as calculated from the Medi-Cal cost report.

6) Each market basket weight shall be multiplied by the corresponding price indicator. The results will be summed to obtain the unadjusted non-pass-through price index.

7) The price indicators for items under I. 3) (c through g) will be established for the end of each calendar quarter (March 31, June 30, September 30 and December 31). Any FPE other than on a calendar quarter shall use the price indicators under 3) above for the quarter in which the provider's FPEs.

   (a) The following five market basket categories and price indicators to be used in developing each provider's IPI are shown in the following table.

NON-PASS THROUGH MARKET BASKET CLASSIFICATION
(Excluding Wages and Benefits)

MARKET BASKET CATEGORIES	PRICE INDICATORS	
	VARIABLE	SOURCE
(1) Professional Fees for Physicians	Physicians' services component	Consumer Price Index, Urban Consumers
(2) Other Professional Fees	Hourly earnings production or non supervisory, private nonagricultural employees	U.S. Department of Labor, Bureau of Labor Statistics
(3) Food	Average of processed foods and feeds component of PPI and food and beverages component of CPI	Producer Price Index Consumer Price Index All Urban Consumer
Drugs	Pharmaceuticals and ethicals component	Producer Price Index
(5) Other costs:		
(a) Chemicals	Chemicals and allied products component	Producer Price Index
(b) Surgical & Medical Instruments and Supplies	Special industry machinery and equipment component	Producer Price Index
(c) Rubber and Plastics	Rubber and plastics	Producer Price Index
(d) Travel	Transportation component	Consumer Price Index All Urban Consumers
(e) Apparel and Textiles	Textile products and apparel component	Producer Price Index
(f) Business Services	Services component	Consumer Price Index All Urban Consumers
(g) All Other	All items	Consumer Price Index All Urban Consumers

b) The price index shall be 1.0 + the percentage increase in each price category as measured by the price indicator, expressed as a proportion.

8) The formula for the hospital IPI shall be:

IPI = (PX1 * PGE1) + (PX2 * PGE2) +
(PX3 * PGE3) + (PX4 * PGE4) +
(ASWI * PGE5) + (AEBI * PGE6) +
(PXO * PGE7)

Where:

IPI = Input Price Index.
PX1 = Price Index for Medical Professional Fees.
PX2 = Price Index for Other Professional Fees.
PX3 = Price Index for Food Costs.
PX4 = Price Index for Drug Costs.
ASWI = Adjusted Salary and Wage Index.
AEBI = Adjusted Employee Benefit Index.
PXO = Price Index for Other Costs.
PGE1 = Proportion of non-pass-through GOE which is for Medical Professional Fees for the prior fiscal period.
PGE2 = Proportion of non-pass-through GOE which is for Other Professional Fees for the prior fiscal period.
PGE3 = Proportion of non-pass-through GOE which is for Food Costs for the prior fiscal period.
PGE4 = Proportion of non-pass-through GOE which is for Drug Costs for the prior fiscal period.
PGE5 = Proportion of non-pass-through GOE which is for Salary and Wages for the prior fiscal period.
PGE6 = Proportion of non-pass-through GOE which is for Employee Benefits for the prior fiscal period.
PGE7 = Proportion of non-pass-through GOE which is for Other Costs for the prior fiscal period.
non-pass-through GOE = GOE minus total of all pass-through costs for the prior fiscal period.

9) Providers that do not supply the data needed to calculate the IPI, shall have an IPI equal to the hospital market basket increase as calculated by HCFA, for the closest corresponding time period. For hospitals with short FPEs, the closest corresponding time period shall be the one with the closest mid-point.

J. A volume adjustment shall be made to the provider's non-pass-through portion of the ARPD for the settlement fiscal period if the number of annualized total hospital discharges in the provider's settlement fiscal period differs from the number of

annualized total hospital discharges in its prior fiscal period. The volume adjustment is used to allocate fixed costs on a per discharge basis. Provider fiscal periods (both settlement and prior) under 360 or over 370 days shall be annualized to a 365 day period based on the following formula:

ATHD = (365/DFP) * THD.

Where:

ATHD = Annualized total hospital discharges.
DFP = Days in fiscal period.
THD = Total hospital discharges.

1) The volume adjustment shall be calculated using the following formula which adjusts the rate per discharge for estimated changes in average costs resulting from changes in volume.

VOLUME ADJUSTMENT FORMULA

AIPI = IPI * VAF

Where:

AIPI = Allowable change in the prior year non-pass-through portion of the APRD after volume adjustment, expressed as a proportion. This is the adjusted IPI, which has not been annualized and does not include any CMAF or SIPTF.

IPI = Hospital Input Price Index.

$$VAF = \frac{DIS_P + (VC * (DIS_F - DIS_P))}{DIS_F}$$

VAF = Volume Adjustment Factor

DIS_P = Total hospital discharges in the prior fiscal period (annualized if needed).

VC = Variable cost as a proportion of total cost for the prior fiscal period.

* = Multiplication.

DIS_F =Total hospital discharges in the settlement fiscal period (annualized if needed).

2) Each provider's total costs, except for pass-through costs, shall be divided into the fixed and variable components shown in the following table. Data from the provider's Medi-Cal cost report or in the event it is unavailable, other direct report of expenses, shall be used to estimate the percentage of a provider's cost which varies with volume. A fixed to variable cost ratio of 50:50 shall be used when sufficient data from the provider are not available.

Approach: Reimbursement to Out-of-State Hospitals for Inpatient Services Provided to Medi-Cal Beneficiaries

Out-of-state hospital inpatient services which have been certified for payment at the acute level and which are either of an emergency nature or for which prior Medi-Cal authorization has been obtained, shall be reimbursed the current statewide average of contract rates for acute inpatient hospital services provided by hospitals with at least 300 beds or the hospital's actual billed charges, whichever is less. Contract rates are negotiated by the California Medical Assistance Commission (CMAC), which annually reports to the California Legislature the average of such rates as of the preceding December 1. The term "current" in this paragraph refers to the most recent average of the contract rates for hospitals with at least 300 beds that CMAC has reported to the Legislature. The average of the contract rates for hospitals with at least 300 beds as of December 1 in a particular calendar year will be the maximum rate paid to out-of-state hospitals for dates of service beginning January 1 of the following calendar year.

Reimbursement to Out-of-State Hospitals for Inpatient Services Provided to Medi-Cal Beneficiaries (continued)

Medi-Cal will adjust payment to out-of-state inpatient hospitals for provider preventable conditions, as described in 4.19-A. When treating a Medi-Cal patient, out-of-state providers must comply with the reporting provisions for provider preventable conditions described in Attachment 4.19-A.