State/Territory California

Citation | Condition or Requirement

REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL

ACUTE INPATIENT SERVICES

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

A. DEFINITIONS

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

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

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

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

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

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

B. REIMBURSEMENT METHODOLOGY FOR NON-NEGOTIATED RATE PROVIDERS

REIMBURSEMENT LIMITS

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

1. The provider's published charge to the general public, unless the provider is a NOMINAL CHARGE PROVIDER (as defined below).

2. The provider's allowable cost.

3. The SMAs established as defined in Section D. by the Department of Mental Health (DMH) and approved by the Department of Health Services (DHS).

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

NOMINAL CHARGE PROVIDER

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

C. REIMBURSEMENT METHODOLOGY FOR NEGOTIATED RATE PROVIDERS

REIMBURSEMENT LIMITS

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

1. The provider's published charge to the general public, unless the provider is a NOMINAL CHARGE PROVIDER (as defined below),

2. The provider's negotiated rates, based on historic cost, approved by the State,

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

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

NOMINAL CHARGE PROVIDER

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

D. SMA METHODOLOGY

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

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

Short Doyle/Medi-Cal Hospitals

1. Santa Barbara County Psychiatric Health Facility
2. San Mateo County Medical Center
3. Gateways Hospital and Community Mental Health Center
4. Riverside County Regional Medical Center
5. Kedren Hospital and Community Mental Health Center
6. Natividad Medical Center
7. LAC/USC Medical Center
8. Contra Costa Regional Medical Center
9. Harbor/UCLA Medical Center
10. Olive View/UCLA Medical Center
11. San Francisco General Hospital
12. Sempervirens Psychiatric Health Facility
13. Ventura County Medical Center
14. Santa Clara Valley Medical Center
15. Alameda County Medical Center
16. Arrowhead Regional Medical Center
17. Rady Children Adolescent Psychiatric Services
18. Mills Peninsula Hospital
19. Stanford University
20. Shasta Psychiatric Hospital

State/Territory California

Citation | Condition or Requirement

REIMBURSEMENT FOR FEE-FOR-SERVICE MEDI-CAL

PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Notwithstanding any other provision of this Plan, the policy of the State Agency is that reimbursement for psychiatric inpatient hospital services to Fee-for-Service/Medi-Cal providers shall be the lower of the provider's customary charges or fixed per diem rates.

A. DEFINITIONS

"Mental Health Plan" (MHP) means an entity which enters into an agreement with the State to provide beneficiaries with psychiatric inpatient hospital services. A MHP may be a county, counties acting jointly, or another governmental or nongovernmental entity.

"Border community" means a town or city outside, but in close proximity to, the California border.

"Administrative day services" means services for a beneficiary residing in an acute psychiatric inpatient hospital when, due to a lack of residential placement options at non-acute treatment facilities, the beneficiary's stay at the acute psychiatric inpatient hospital must be continued beyond the beneficiary's need for acute care.

"Fee-for-Service/Medi-Cal provider means a provider who submits claims for Medi-Cal psychiatric inpatient hospital services through the State's fiscal intermediary.

"Hospital-based ancillary services" means services other than routine services that are received by a beneficiary admitted to a psychiatric inpatient hospital.

"Routine services" means bed, board, and all medical, nursing, and supportive services normally provided to an inpatient by an acute psychiatric inpatient hospital. Routine services do not include hospital-based ancillary services or physician or psychologist services that are separately billed.

"Allowable psychiatric accommodation code" means a reimbursable hospital billing code, based on room size and type of service, that may be used by Fee-for-Service/Medi-Cal providers to claim payment for psychiatric inpatient hospital services provided to beneficiaries.

B. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES FOR CONTRACT, FEE-FOR-SERVICE/MEDI-CAL PROVIDERS.

1. Reimbursement for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal provider shall be based on a per diem rate established through negotiations between the provider and the Mental Health Plan (MHP) county in which the provider is located except when:

    a. The MHP from the county in which the provider is located delegates the rate negotiation responsibilities to an MHP in another county with the agreement of that MHP.

    b. The provider is located in a border community and an MHP wants to negotiate rates. The MHP shall request approval from the Department of Mental Health (DMH) to be designated as the negotiator.

    c. A provider is owned or operated by the same organizational entity as the MHP, in which case, the per diem rate must be approved by DMH.

2. The per diem rate shall include routine services and all hospital-based ancillary services.

3. Only one rate for each allowable psychiatric accommodation code for each Fee-for-Service/Medi-Cal provider may be established and shall be used by all MHPs. The negotiated rate shall not be subject to retrospective adjustment to cost.

4. Reimbursement for administrative day services shall be based on the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services, plus an allowance for the cost of ancillary services equal to 25 percent of the prospective class median rate.

5. For both acute psychiatric inpatient hospital services and administrative day services, interim reimbursement to the provider shall be based on the per diem rate, net of third party liability and patient share of cost, but never to exceed the provider's customary charge.

6. The provider shall bill its customary charges.

7. At the end of each fiscal year, DMH shall compare, in aggregate, customary charges to per diem rate for each provider. Future claims shall be offset by the amount that the per diem rate exceeds the customary charges for that fiscal year.

8. The Medi-Cal payment constitutes payment in full.

9. These provisions will be in effect from January 1, 1995, until such time as the State's pending and related 1915(b) waiver is approved.

C. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES FOR NON-CONTRACT, FEE-FOR-SERVICE/MEDI-CAL PROVIDERS

1. Reimbursement rates for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal provider with no contract with any MHP, shall be determined by DMH.

    a. The reimbursement rates in (1.) shall be calculated by DMH prior to the beginning of each fiscal year and shall not be modified for subsequent rate changes among contract providers or the addition of new contract providers.

    b. One rate per allowable psychiatric accommodation code per non-contract, Fee-for-Service/Medi-Cal provider per Rate Region listed in (9.) shall be established and shall be used by all MHPs.

    c. The rates shall not be subject to retrospective adjustment to cost.

2. The per diem rate includes routine services and all hospital-based ancillaries.

3. The per diem rate shall equal the weighted average per diem rates negotiated for all Fee-for-Service/Medi-Cal providers within the Rate Region where the non-contract provider is located and shall be based on the following information from each Fee-for-Service/Medi-Cal hospital with a contract in the Rate Region where the non-contract provider is located:

    a. The latest available fiscal year Medi-Cal paid claims data for Fee-for-Service/Medi-Cal acute psychiatric inpatient hospital services patient days.

b. The negotiated per diem rates for the subsequent fiscal year.

4. Reimbursement for administrative day services shall be based on the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services, plus an allowance for the cost of ancillary services equal to 25 percent of the prospective class median rate.

5. For both acute psychiatric inpatient services and administrative day services, interim reimbursement to the non-contract, Fee-for Service/Medi-Cal provider shall be based on the calculated per diem rate, net of third party liability and patient share of cost, but never to exceed the provider's customary charge.

6. The provider shall bill its customary charges.

7. At the end of each fiscal year, DMH shall compare, in aggregate, the customary charges to the per diem rate for each provider. Future claims shall be offset the amount that the per diem rate exceeds the customary charges for that fiscal year.

8. The Medi-Cal payment constitutes payment in full for acute psychiatric inpatient hospital services.

9. The Rate Regions are:

   a. Superior - Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama and Trinity Counties and the border communities of Grants Pass, Klamath Falls, Lakeview, and Medford, Oregon.

   b. Central Valley - Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo and Yuba Counties and the border communities of Carson City, Incline Village, Reno, and Sparks, Nevada.

   c. Bay Area - Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano and Sonoma Counties.

d. Southern California - Imperial, Inyo, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara and Ventura Counties and the border communities of Las Vegas, and Yerington, Nevada, and Kingman and Yuma, Arizona.

e. Los Angeles County

10. These provisions shall take effect January 1, 1995.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO SPECIFIED GOVERNMENT-OPERATED HOSPITALS FOR INPATIENT HOSPITAL SERVICES

Notwithstanding any other provision of this State Plan, reimbursement for the costs of inpatient hospital services described in this segment of Attachment 4.19-A that are provided to Medi-Cal beneficiaries by government-operated hospitals meeting the requirements below will be governed by this segment of Attachment 4.19-A.

A. Eligible Hospitals

1. Hospitals eligible for reimbursement under this segment of Attachment 4.19-A are government-operated hospitals specified in Appendix 1 to this Attachment 4.19-A, and any other government-operated hospitals receiving approval of the Centers for Medicare & Medicaid Services.

B. General Reimbursement Requirements

1. Except as provided in subparagraphs B.2 and B.3, below, payments to eligible hospitals for inpatient hospital services rendered to Medi-Cal beneficiaries, exclusive of psychiatric services and professional services, will be determined on a cost basis in accordance with this segment of Attachment 4.19-A.

2. Eligible hospitals may receive payments for specified inpatient hospital services that are paid independent of the cost-based payments specified in subparagraph B.1. Services to be paid pursuant to this subparagraph B.2 will be determined by the State. Such payments will be appropriately offset against the hospital's costs pursuant to subparagraph C.1.d, subparagraph D.3, and subparagraph E.4.

3. Eligible hospitals will receive supplemental payments for hospital facility construction, renovation or replacement pursuant to California Welfare and Institutions Code section 14085.5 and disproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment.

4. The hospital's Medi-Cal 2552-96 cost report with fiscal years prior to May 1, 2010 or Medi-Cal 2552-10 for fiscal years beginning on or after May 1, 2010, will be the basis for determining the reimbursable costs under this segment of Attachment 4.19-A.

a. The term "finalized Medi-Cal 2552-96 or 2552-10 cost report" refers to the cost report that is settled by the California Department of Health Services, Audits and Investigations (A&I) with the issuance of a Report On The Cost Report Review (Audit Report).

b. The term "filed Medi-Cal 2552-96 or 2552-10 cost report" refers to the cost report that is submitted by the hospital to A&I and is due five months after the end of the cost reporting period.

c. Los Angeles County hospitals (to the extent that they, as all-inclusive-charge-structure hospitals, have been approved by Medicare to use alternative statistics, such as relative value units, in the cost report apportionment process) may also use alternative statistics as a substitute for charges in the apportionment processes described in this segment of Attachment 4.19-A. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

5. Nothing in this segment of Attachment 4.19-A shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicaid program. Any revision to the finalized Audit Report as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

C. Interim Per Diem Rates

For each eligible hospital, an interim per diem rate will be computed on an annual basis using the following methodology:

1. Using the most recently filed Medi-Cal 2552-96 or 2552-10 cost report, the cost apportionment process as prescribed in the Worksheet D series will be applied to arrive at the total Medicaid non-psychiatric inpatient hospital cost.

a. On the Medi-Cal 2552-96 or 2552-10 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26 on the Medi-Cal 2552-96 or column 25 on the Medi-Cal 2552-10 cost report. If the costs have been removed, the allowable interns and residents costs will be added back to each affected cost center prior to the computation of cost-to-charge ratios on Worksheet C. This can be accomplished by using Worksheet B, Part I, column 25 (instead of column 27) on the Medi-Cal 2552-96 for the Worksheet C computation of cost-to-charge ratios or column 24 (instead of column 26) on the Medi-Cal 2552-10 cost

report. Only those allowable interns and residents costs that are consistent with Medicare cost principles will be added back. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as Graduate Medical Education (GME) under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

b. For hospitals that remove Medicaid inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), necessary adjustments will be made to the Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 or 2552-10 worksheets) to account for the Medicaid inpatient dental services. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

c. The CDHS will perform those tests necessary to determine the reasonableness of the Medicaid program data (i.e., Medicaid days and Medicaid charges) from the reported Medi-Cal 2552-96 or 2552-10 cost report's Worksheet D series. This will include reviewing the Medicaid program data generated from its MMIS/claims system for that period which corresponds to the most recently filed Medi-Cal 2552-96 or 2552-10 cost report. However, because the MMIS/claims system data would generally not include all paid claims until at least 18 months after the Fiscal Year Ending (FYE) of the cost report, the CDHS will take steps to verify the filed Medicaid program data, including the use of submitted Medicaid claims. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

d. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost before a per diem is computed in subsection 2. below.

2. The Medicaid non-psychiatric inpatient hospital cost computed in subsection 1. above should be divided by the number of Medicaid non-psychiatric inpatient hospital days as determined in subsection 1 above for that period which corresponds to the most recently filed Medi-Cal 2552-96 or 2552-10 cost report.

3. The Medicaid per day amount computed in subsection 2 above will be trended to current year based on Market Basket update factor(s) or other approved hospital-related indices. The Medicaid per day amount may be further adjusted to reflect

increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

a. Inpatient hospital costs not reflected on the filed Medi-Cal 2552-96 or 2552-10 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 or 2552-10 cost report for the current year to which the interim rate will apply.

b. Inpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 or 2552-10 cost report from which the interim payments are developed, but which would not be incurred and not reflected on the Medi-Cal 2552-96 or 2552-10 cost report for the current year to which the interim rate will apply.

Such costs must be properly documented by the hospital, and are subject to review. The result is the Medicaid non-psychiatric inpatient hospital cost per day amount to be used for interim Medicaid inpatient hospital payment rate purposes.

4. The CDHS may apply an audit factor to the filed Medi-Cal 2552-96 or 2552-10 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 or 2552-10 cost reporting periods for which final determinations have been made. The CDHS will identify such percentage to CMS.

D. Interim Reconciliation

1. Each eligible hospital's interim Medicaid payments with respect to services rendered in a fiscal year will be reconciled to its filed Medi-Cal 2552-96 or 2552-10 cost report for that same fiscal year.

2. The hospital's total Medicaid non-psychiatric inpatient hospital costs shall be determined using its filed Medi-Cal 2552-96 or 2552-10 cost report for the applicable fiscal year and applying the steps set forth in paragraphs a – c of subsection 1 of Section C.

3. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, along with the interim Medicaid payments received for services rendered in the fiscal year, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost.

4. The CDHS may apply an audit factor to the filed Medi-Cal 2552-96 or 2552-10 cost report to adjust computed cost by the average percentage change from total

reported costs to final costs for the three most recent Medi-Cal 2552-96 or 2552-10 cost reporting periods for which final determinations have been made.

5. If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, appropriate adjustments will be made to offset or otherwise recover the overpayment.

E. Final Reconciliation

1. Each eligible hospital's interim payments and interim adjustments with respect to services rendered in a fiscal year subsequently will be reconciled to its Medi-Cal 2552-96 or 2552-10 cost report for that same fiscal year as finalized by A&I for purposes of Medicaid reimbursement.

2. The hospital's total Medicaid non-psychiatric inpatient hospital costs shall be determined using its finalized Medi-Cal 2552-96 or 2552-10 cost report and applying the steps set forth in paragraphs a – b of subsection 1 of Section C.

3. In computing the Medicaid non-psychiatric inpatient hospital cost from the finalized Medi-Cal 2552-96 or 2552-10 cost report, the Medicaid program data (such as Medicaid days and charges) on the finalized cost report Worksheet D series will be updated as necessary using Medicaid program data generated from its MMIS/claims system for the respective cost reporting period. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

4. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, along with the interim Medicaid payments and interim adjustments received for services rendered in the fiscal year, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost.

5. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, appropriate adjustments will be made to offset or otherwise recover the overpayment.

section 14085.5, and disproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment, are not offset.

5. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, appropriate adjustments will be made to offset or otherwise recover the overpayment.