MEDI-CAL SUPERIOR SYSTEMS WAIVER (SSW) RENEWAL

October 1, 2024, through September 30, 2029

Table of Contents

I. PURPOSE OF WAIVER....2
II. SUMMARY....2
III. HOW THE SSW PROGRAM IS SUPERIOR TO SECTION 1861(k) OF THE SOCIAL SECURITY ACT....3
Tribal Notification:....4
Exempt Inpatient Services:....4
IV. HISTORICAL OVERVIEW OF THE SSW PROGRAM OPERATIONS....4
V. CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CalAIM) INITIATIVE....6
VI. SSW PROGRAM QUALITY ASSURANCE....6
A. Managing Provider Variability....6
B. Managing Adjudication Variability Within DHCS....8
C. Variance Data (Adjudication)....9
D. Other Analyses....10
VII. COMPARISON OF THE 2024-2029 SSW UR PROCESSES TO THE MEDICAID UTILIZATION CONTROL REQUIREMENTS (TITLE 42, CODE OF FEDERAL REGULATIONS)....10
Crosswalk Table Overview....10
Attachments....13

Type of Waiver:	Section 1903(i)(4) of the Social Security Act
Proposed Renewal Term:	October 1, 2024, through September 30, 2029
Program Services Area:	Statewide
California Department of Health Care Services (DHCS) Contact:	Paul Miller, M.A., Interim Division Chief Clinical Assurance Division (CAD)

I. PURPOSE OF WAIVER

The purpose of the Superior Systems Waiver (SSW) is to allow California to effectively manage and control unnecessary and excessive utilization of Medi-Cal Fee-for-Service (FFS) acute inpatient services. Under the authority of the SSW, California achieves this goal by employing a thorough and thoughtful utilization review (UR) plan that best meets the needs of distinct hospital types in California.

II. SUMMARY

Section 1903(i)(4) of the Social Security Act (SSA) provides that to participate in Medicaid, a hospital or skilled nursing facility must have a UR Plan in effect that meets the requirements set forth in Section 1861(k). This section states, in part, that a hospital's utilization review plan shall be considered sufficient if it provides on a sample or other basis, a review of admissions and duration of stays in the hospital, and that such reviews must be made by staff committee or group outside the hospital by appropriate personnel. Section 1903(i)(4) also provides that the requirements can be waived when a State Medicaid Agency, like the California Department of Health Care Services (DHCS), demonstrates to the satisfaction of the Secretary that it has UR procedures in operation that are superior in their effectiveness to the federal requirements.

In California, general acute care hospitals (GACHs) providing Medi-Cal FFS acute inpatient services must be Medicare/Medicaid program certified and meet all state and federal utilization review requirements, including those set forth in Section 1861(k). Under SSW authority, DHCS sets forth more stringent criteria by employing the following UR approaches, depending on the type of acute inpatient service, the hospital type, and the characteristics of the beneficiary's health care coverage.

- **Treatment Authorization Request (TAR) process:** The TAR process requires DHCS to authorize inpatient hospital services prior to approving reimbursement. Hospitals submit TARs to DHCS for review and approval of admissions to ensure medical necessity is met prior to claiming for services.

- **TAR-Free process:** The TAR-Free process requires hospitals to use evidence-based, standardized medical review criteria to determine medical necessity and claim for inpatient hospital services, while DHCS performs post-payment clinical and administrative compliance reviews using statistically valid[1] samples of paid inpatient hospital claims.

[1] DHCS uses a statistically valid probability sampling done in conformance with generally accepted statistical standards and procedures described in any textbook on statistical sampling methods. Typically, if a variance of 10 percent or more is found then DHCS drills down with more focused reviews.

Attachment 1 provides additional details on how these two approaches are currently utilized.

III. HOW THE SSW PROGRAM IS SUPERIOR TO SECTION 1861(k) OF THE SOCIAL SECURITY ACT

Under the authority of the SSW, DHCS uses the TAR and TAR-Free processes to effectively manage and control unnecessary and excessive utilization of acute inpatient services making California's UR plan **superior** to federal UR requirements alone for the following reasons.

1. State-employed skilled professional medical personnel (SPMP), physicians and nurses, who are also known as Medi-Cal Consultants, perform **independent** pre- and post-payment clinical and administrative compliance reviews. In contrast, federal regulations require a hospital to perform its own UR by a staff committee or group outside the hospital, with appropriate personnel.

2. Continuous and real-time UR feedback provided under California's UR plan via the TAR and TAR-Free processes offers hospitals a **superior fiduciary function** for managing federal, state, and local funding issues and an **exceptional administrative function** regarding time and labor spent upfront performing satisfactory UR. This is instead of relying solely on periodic random auditing to evaluate a hospital's UR activities. Working upfront can reduce the need for comprehensive audits and lower recoupment amounts, because DHCS works more closely with providers.

3. Medi-Cal Consultants regularly oversee decision-making of statewide hospital UR programs, which provides **a more agile approach** that prioritizes potential remediation using uniform standards and identification of outlier performance over audits that may occur years later. In contrast, federal regulations require a hospital to complete medical care evaluation studies to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

4. Formal appeal processes under California's UR plan provide **additional due process** for providers and beneficiaries denied authorizations for acute inpatient hospital days. These formal processes incorporate an independent review of denials through either Medi-Cal Consultants or Administrative Law Judges, depending on whether the appeal is requested by a provider or a beneficiary.

5. The required application of **evidence-based standardized medical review criteria**, such as InterQual®, MCG®, or similar processes, ensures hospitals use clinical decision support tools based on nationally recognized peer-reviewed medical standards when claiming services. Medi-Cal Consultants also use evidence-based standardized medical review criteria when reviewing sample claims under the TAR-Free process. This is considered superior to federal regulations that require hospitals to develop hospital-specific written criteria to define their own UR guidelines.

6. Certain hospitals are reimbursed using the **All Patient Refined-Diagnosis Related Groups (APR-DRGs)** calculation software, the nationwide standard for classifying hospital inpatient utilization, costs, and quality in non-Medicare populations. Medi-Cal Consultants review APR-DRG claims to determine medical necessity and to look for patterns of inappropriate billing, such as unsubstantiated diagnoses/procedures resulting in up-coded DRGs and evidence of altered documentation in the medical record. This is considered superior to federal regulations requiring hospitals to develop hospital-specific written criteria to define their UR guidelines.

Tribal Notification:
The Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) informed DHCS on November 8, 2023, that that tribal notification for this SSW renewal was not necessary.

Exempt Inpatient Services:

1. **Indian Health Services**

- The SSW excludes Indian Health Inpatient Facilities in the Phoenix border area because the UR is conducted in accordance with Title 42, Code of Federal Regulations, Part 456, Subpart C, utilizing the federal method.

- The excluded inpatient facilities are Phoenix Indian Medical Center and Parker Indian Health Center.

2. **TAR-Free Obstetrical Acute Care**

Routine deliveries in an acute inpatient care hospital do not require a TAR to be submitted to Medi-Cal for review of medical necessity for the first two days before and after a vaginal delivery and the first two days before and four days after a caesarean section.

3. **Psychiatric Services**

Primary psychiatric admissions are the financial responsibility of California's counties and are not relevant to the SSW.

IV. HISTORICAL OVERVIEW OF THE SSW PROGRAM OPERATIONS

Beginning in 1982, DHCS (formerly the Department of Health Services) operated the Selective Provider Contracting Program (SPCP) via a federal Section 1915(b) waiver that allowed Medi-Cal to selectively contract with hospitals to provide general acute care inpatient services to beneficiaries at negotiated per diem rates. SPCP contract hospitals were paid via these negotiated rates (eligible hospitals also received supplemental reimbursements in the form of inter-governmental transfers) in lieu of the Certified Public Expenditures (CPEs) and APR-DRGs used today. UR management of SPCP contracted services required Medi-Cal Consultants, to review 100 percent of all hospital days via the TAR process to determine if services provided were medically necessary and covered by the Medi-Cal program.

In 2005, CMS approved Medi-Cal's initial Section 1115 demonstration waiver, i.e., the *Medi-Cal Hospital/Uninsured Care Demonstration Waiver*, which allowed DHCS to begin to phase out the SPCP. This waiver established three distinct hospital types in California -- i.e., Designated Public Hospitals (DPHs), Non-Designated Public Hospitals (NDPHs), and Private Hospitals -- and significantly changed the way in which Medi-Cal paid hospitals for FFS acute inpatient services by phasing out the use of inter-governmental transfers and allowing DHCS to use CPEs as the non-federal share of Medi-Cal expenditures for DPHs. California's 21 DPHs are the state's safety-net hospitals and include county-owned or affiliated systems and University of California academic medical centers.

In 2008, DHCS piloted a TAR-Free process wherein DPHs began performing their own acute inpatient UR using evidence-based standardized medical review criteria, such as InterQual® or MCG® to establish medical necessity and claim for services. Simultaneously, DHCS began transitioning its UR management approach from Medi-Cal Consultants reviewing 100 percent of all hospitals days to conducting post-payment clinical and administrative compliance reviews using statistically valid samples of paid inpatient hospital claims to ensure federal funds were claimed appropriately. Since 2013-14, all DPHs remain TAR-Free, although a DPH may be put back on TAR for a period of time due to TAR-Free performance issues.

On July 1, 2013, and January 1, 2014, respectively, all Private Hospitals and NDPHs transitioned from billing each day of an approved acute inpatient stay to a payment methodology based on APR-DRGs, as mandated by Welfare and Institutions Code Section 14105.28. As a result of this change in payment methodology, Medi-Cal's SPCP was fully eliminated, and NDPHs and Private Hospitals transitioned from submitting a TAR to the field office for each day of a hospital stay to submitting a TAR for an admission only to ensure medical necessity was met.

In April 2016, DHCS began transitioning NDPHs and Private Hospitals to the TAR-Free process using evidence-based standardized review criteria, such as InterQual® or MCG®. As part of this effort, DHCS began reviewing paid claim samples to ensure hospitals appropriately used standardized medical review criteria and to ensure that acute inpatient services provided were medically necessary. Approximately 100 NDPHs and Private Hospitals have transitioned to the TAR-Free process to date, and the transition of additional hospitals continues today. Initially, DHCS anticipated the TAR-Free process would negate the need for TARs. However, experience indicates TAR-Free may not always be the preferred UR approach when DHCS has compliance concerns or when hospitals serve a low volume of Medi-Cal beneficiaries.

As part of the 2024-25 Governor's Budget Proposed Plan, California initiated several Medi-Cal targeted rate increases, including the transition of DPH reimbursement for inpatient services from the existing CPE methodology to an APR-DRG methodology, effective January 1, 2025. Although not enacted this budget year, if enacted in future budget years, DHCS will change its UR process for DPHs from reviewing each acute day within the sample to reviewing for admission only to ensure medical necessity is met. This would align the reimbursement and TAR-Free UR process for DPHs with the current reimbursement and TAR-Free UR process for NDPHs and Private Hospitals. If this occurs, DHCS will provide CMS with progress updates on implementing this new reimbursement methodology.

DHCS has operated five Medi-Cal field offices in Los Angeles, Sacramento, San Bernardino, San Diego, and San Francisco. Medi-Cal Consultants assigned to these field offices are responsible for the UR of inpatient services within their respective areas, and they functioned with physical presence until the onset of the COVID-19 pandemic. Following the pandemic's emergence in 2020, they transitioned from on-site operations to remote work environments, successfully performing UR activities virtually. Before the pandemic, office staff had already been engaged in TAR-Free reviews virtually. Medi-Cal Consultants continue to work virtually unless required to do in-person and site-based functions, including training, stakeholder meetings, or other events or meetings. Medi-Cal Consultants also have the option to work in shared or hoteling spaces at State offices in the cities above.

Attachment 2 provides a historical timeline of the utilization review approach and payment methods used in prior SSWs.

V. CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CalAIM) INITIATIVE

In January 2022, DHCS launched its CalAIM initiative to broadly transform and reform Medi-Cal programs and systems over the span a multi-year period, with the first reforms implemented in January 2022 and additional reforms phased in through 2027. These initiatives, including the expanded coverage of Medi-Cal managed care, are expected to gradually reduce the Medi-Cal FFS population, though complete elimination is not anticipated. Given the complexity of California's Medicaid program, estimating the number of members that will remain in FFS once CalAIM is fully implemented is challenging. At present, it is estimated that there is approximately five percent of the total Medi-Cal population (currently 15 million) in FFS. However, once the multi-year initiative is fully implemented, no sooner than January 1, 2027, DHCS anticipates approximately one percent of Medi-Cal members will remain in FFS. It is important to note that FFS members also utilize a disproportionately higher volume of services. As such, the SSW remains an important program for overseeing hospital UR by providing in depth and independent clinical oversight and monitoring in Medi-Cal's FFS program.

VI. SSW PROGRAM QUALITY ASSURANCE

Under the SSW, consistency and standardization are the cornerstones of California's UR plan. To this end, DHCS strategically manages the variability of provider practice patterns and statewide staff adjudications.

A. Managing Provider Variability

DHCS manages the variability of provider practice patterns in two significant ways – via the TAR-Free Process and the use of APR-DRGs – plus additional activities.

1. **Required Use of Evidence-based Standardized Medical Review Criteria (TAR-Free only)**: Under the TAR-Free process, hospitals must use current evidence-based standardized medical review criteria, such as InterQual®, MCG®, or similar processes, when claiming for services. These criteria provide clinical decision support to providers to help ensure clinically appropriate medical utilization decisions are made. The review criteria are developed using nationally recognized peer-reviewed medical standards that help ensure consistency and

standardization in the rapidly evolving field of medicine. Post-payment clinical and administrative compliance reviews using statistically valid samples of paid acute inpatient hospital claims are then performed by DHCS.

Compliance reviews under the TAR-Free process are completed by Medi-Cal Consultants who virtually access a hospital's electronic health record system to review medical records for the selected sample claims. Each claim is reviewed against the strict guidelines set forth in the TAR-Free Participation Agreement. Failure to comply with the guidelines can result in recoupment of paid funds. When negative patterns or trends are discovered for the DPH and DRG TAR-Free programs, the monthly sample of claims pulled for review may increase if the hospital does not improve to address the issues. If issues with noncompliance persist, DHCS reserves the right to remove a hospital from the TAR-Free Program and place them back on 100% TAR review.

- **Participation Agreements**: Before transitioning to the TAR-Free process, hospitals must sign a Participation Agreement, a vital tool in ensuring hospital compliance. These agreements delineate the primary requirements the hospital must meet to participate in the TAR-Free process, including information on claiming and reporting requirements, the UR process, maintaining a UR Committee, and a secondary review process. Providers renew, and DHCS approves, these agreements annually.

- **Hospital Training:** As part of hospital onboarding, Medi-Cal Consultants train hospital UR staff on the process, program requirements, and relevant Medi-Cal policies before a hospital begins the TAR-Free process. Training specific to Medi-Cal criteria that are not captured using standardized review criteria (e.g., acute administrative days and restricted aid codes) is also provided. Ongoing training, technical assistance, and clarification regarding clinical review findings and current policy information are made available directly to providers and memorialized in the Medi-Cal Provider Manual and DHCS websites.

- **Dispute Resolution:** Similar to a TAR appeal, a dispute resolution process exists for clinical findings under the TAR-Free process. If a hospital disagrees with a DHCS clinical finding, it may submit a Dispute Resolution form electronically with attached documentation to support the reason(s) for the dispute. A DHCS Medi-Cal Consultant will review the documentation and make an independent determination to uphold or reverse the determination in part or whole.

- **Alternative Method of Utilization Review:** If a hospital is deemed non-compliant with the requirements that govern the TAR-Free process, DHCS may require the hospital to revert to the TAR process.

2. **Use of APR-DRGs (TAR & TAR-Free):** DHCS also manages variability in local, regional, and statewide hospital provider practice patterns by using APR-DRGs to reimburse NDPH and Private Hospitals. APR-DRG reimbursement calculation software is the nationwide standard for classifying hospital inpatients in non-Medicare populations. APR-DRGs are routinely updated using nationally recognized measurements based on provider studies conducted across the United States that provide insight into utilization, costs, and quality of inpatient hospital services.

3. **Pre- and -Post-Payment Review:** Medi-Cal Consultants use their clinical expertise and professional judgment to perform independent pre- and post-payment clinical and administrative compliance reviews in both the TAR and TAR-Free processes. Medi-Cal Consultants maintain continuing education required for their licensure and remain informed of new evidence-based and evolving clinical practices. They are uniquely qualified to identify clinical trends, analyze situations, and provide providers with technical [and Medi-Cal policy discernment] related assistance. This is accomplished by providing immediate and individualized provider outreach and education to address provider training needs. DHCS is committed to working directly with providers and hospital associations on all of California's UR plan matters and ensuring effective management and control of unnecessary and excessive utilization of acute inpatient services.

4. **Provider Training:** Medi-Cal's fiscal intermediary, the California Medicaid Management Information System (CA-MMIS), also provides quarterly training sessions for providers at several locations throughout the state. The basic training covers how to request a TAR and how to bill the program. There are also advanced training sessions that cover more complex issues such as Medicare crossover claims and other health care coverage. DHCS also holds quarterly meetings with hospital associations to help ensure continuous communication with its partner providers. This is another forum in which DHCS provides on-going training, technical assistance, and general clarification regarding clinical review findings.

5. **Referral to Audits & Investigations**

   There is a potential for referral to DHCS Audits & Investigations (A&I) if:
   - Continued issues with the UR process are identified;
   - Claims for hospital stays are not reprocessed as requested by DHCS; and/or
   - Hospital staff training issues identified by DHCS are not corrected.

   A referral to A&I would only occur after DHCS staff have provided training and technical assistance to a subject hospital and have adequately worked with the hospital to correct any deficiencies identified by DHCS.

B. Managing Adjudication Variability Within DHCS

DHCS places high importance on creating detailed, comprehensive, and rigorous Standard Operating Procedures (SOPs) that are clear, consistent, and reflect medical consultation and documentation requirements standards. These SOPs, available to staff at any time provide a uniform reference for adjudicating TARs and overseeing hospitals participating in the TAR-Free process. The SOPs describe legislative and regulatory authorities, adopted policies, key contacts, step-by-step procedures, and roles and responsibilities in a thorough manner. They also include visual process flows to illustrate the sequence of actions and are supplemented with job aids to support different learning styles. SharePoint is used as an online tool to store existing SOPs and disseminate new and revised SOPs. Moreover, information on new and revised SOPs is continuously communicated electronically via statewide email to all levels of staff, ensuring everyone is kept up to date.

On-going staff adherence with written SOPs is continuously monitored by nurse and physician supervisors, as well as branch managers, to help ensure workforce controls remain adequate. In turn, findings from this monitoring are routinely shared with executive management so deficiencies can be immediately addressed. Data-driven monitoring oversees staff utilization and performance.

Specifically, daily reports provided to all supervisors and managers include an “over 24-day” report indicating all TARs pending adjudication over 24 days since receipt, specific reports for each field office of all TARs adjudicated the previous day further broken down at a consultant level, and includes the adjudication decisions, as well as a weekly SURGE report of all TARs in inventory. SURGE (Service Utilization Review, Guidance and Evaluation) is the computerized technical system that in turn serves CA-MMIS for processing Medi-Cal FFS claims.

These reports allow management to monitor staff output and alert management of any needs to re-route TARs. In addition, reports can indicate unusual patterns viewed in an at-a-glance format (for example, high deferral rates the previous day could indicate a technical issue with freeform documents in SURGE or staff productivity and need for additional training and workload adjustments.

Regularly scheduled statewide Medi-Cal Consultant staff meetings and training sessions reinforce existing guidelines and provide opportunities to learn about new issues. Senior Medi-Cal Consultants in DHCS’ Benefits Division also create and disseminate new and revised policies gained by researching newly released publications, studies, and standards of practice. After adequate training, policies are adopted and implemented statewide, as appropriate.

C. Variance Data (Adjudication)

One of the key components of monitoring and evaluating UR management under the SSW is the review and analysis of variance data to discern patterns of adjudication that change in an unexpected manner over time. DHCS Medi-Cal Consultants and analytical research staff support activities to identify variability among adjudication decisions so that actions can be taken to maintain consistency.

As shown below, TAR statistics for Calendar Years 2005 through 2023 indicate an upward trend in approval rates. DHCS believes this is due in large part to providers' clearer understanding of medical necessity, the increased use of evidence-based standardized medical review criteria, and the implementation of the APR-DRG payment methodology for NDPHs and Private hospitals.

Note that three percent of acute inpatient hospital-denied TARs in 2023 are attributed to CalAIM. As Medi-Cal members were transitioning from FFS to managed care, some TARs were incorrectly submitted to FFS, resulting in administrative denials.

Acute Inpatient Hospital

Year	TAR Approval Rate
2005	70%
2006	77%
2007	79%

2008	83%
2009	78%
2010	82%
2011	83%
2012	82%
2013	81%
2014	86%
2015	88%
2016	89%
2017	88%
2018	88%
2019	91%
2020	92%
2021	94%
2022	94%
2023[i]	91%

D. Other Analyses

Other routine analyses performed to help minimize variability include:

- Regularly generated reports are used to monitor TAR volume and processing times statewide by TAR type, including approval, denial, deferral, and modification rates for all TARs.
- Fair hearings, appeals, dispute resolution, and litigation decisions are also tracked and analyzed to identify areas in need of policy clarification.

VII. COMPARISON OF THE 2024-2029 SSW UR PROCESSES TO THE MEDICAID UTILIZATION CONTROL REQUIREMENTS (TITLE 42, CODE OF FEDERAL REGULATIONS)

Crosswalk Table Overview

As reflected in the attached Crosswalk Table, California hospitals providing Medi-Cal FFS acute inpatient services must be Medicare/Medicaid program certified and meet all state and federal utilization review requirements, including those set forth in Section 1861(k).

Hospitals in California are required to comply with specific health and safety, licensing and certification laws and regulations, including:

- Health and Safety Code (HSC), Division 2. Licensing Provisions, Chapter 2. Health Facilities. Article 1 of Chapter 2 commences with § 1250, which defines a general acute care hospital (GACH) as a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides

24-hour inpatient care. Article 1 also includes requirements related, but not limited to, privacy and security of protected health information, medical records system, discharge planning policy and process, and ensuring information regarding a patient's rights is made available upon admission.

- WIC, Division 9. Public Social Services, Part 3. Aid and Medical Assistance, Chapter 7. Basic Health Care. Chapter 7 includes Article 1. General Provisions and Article 1.3. Provider Enrollment, Application, and Participation, which ensures the proper and efficient administration of the Medi-Cal program by ensuring all providers, including GACHs, are subject to provider enrollment, application, and participation requirements. This includes, but is not limited to, compliance with all applicable state and federal laws and regulations. Chapter 7 also includes Article 4. Medi-Cal Benefits Program §§ 14131 - 14138, which defines inpatient hospital services under the schedule of Medi-Cal benefits. WIC §10950 also requires that if any applicant for or recipient of public social services is dissatisfied with any action taken by the county or state be afforded an opportunity for a state hearing.

- Title 22, CCR, Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, Chapter 1. General Acute Care Hospitals. Article 1 of Chapter 1 defines GACH and basic services and Article 7 of Chapter 1 includes administration requirements, including those related but not limited to the organization of medical staff, interdisciplinary practice and responsibility for patient care, standardized procedures, patient rights, admission, transfer and discharge policies, records and reports, medical records, patient health record content, and medical record availability.

- Title 22, CCR, Division 3. Health Care Services, Subdivision 1. California Medical Assistance Program, Chapter 3. Health Care Services. Article 2 of Chapter 3 defines inpatient hospital services and Article 1 of Chapter 3 includes administration requirements, including those related but not limited to Medi-Cal program application, enrollment and provider agreement requirements, maintenance of confidential records, and state hearings related to denial, termination or reduction in medical services. Article 3 of Chapter 3 sets forth requirements for participation in the Medi-Cal program, including the requirement that a hospital must be certified, or meet the requirements for certification under Title XVIII of the Federal Social Security Act, be licensed pursuant to the provisions of Chapter 2 of the HSC, and have an organized medical staff that has promulgated medical staff by-laws, rules, and regulations which include provisions that assure correct utilization and high quality of professional services rendered to Medi-Cal beneficiaries in the hospital. Article 4 of Chapter 3 also includes requirements related to admissions, continued stays, and certification/recertification of need for inpatient care.

- Medi-Cal Provider Manual (patient ip), *Patient Plans of Care for Inpatient Facilities*, which specifies that individual written plans of care are federally required and must be approved and signed by a physician. This section also specifies what a plan of care should include per federal regulations.

Compliance is also required via the terms and conditions set forth in the Medi-Cal Provider Agreement (DHCS 9098), which requires compliance with all applicable state and federal laws, regulations, and requirements.

Under SSW authority, DHCS sets forth more stringent criteria by providing in depth and independent clinical oversight and monitoring to determine if services provided are medically necessary. DHCS uses the TAR and TAR-Free processes to effectively manage and control unnecessary and excessive utilization of acute inpatient services making California's UR plan **superior** to federal UR requirements alone.

As reflected in Attachment 3 under both TAR and TAR-Free processes, Medi-Cal Consultants review the following documents provided by hospitals when claiming for acute care inpatient services:

- Certification and recertification of need for inpatient care (§ 456.60);
- Written plan of care (§ 456.80);
- Need for admission, including ensuring a thorough preadmission screening is completed for acute inpatient intensive rehabilitation services (§§ 456.121 through 456.127); and
- Review of need for continued stay (§§ 456.131 through 456.136).

The TAR-Free requirement that providers must use nationally recognized evidence-based standardized medical review criteria, such as InterQual® or MCG® to claim for services, coupled with the use of APR-DRGs for both the TAR and TAR-Free processes, allows Medi-Cal Consultants to more uniformly determine appropriate utilization for both initial and continued inpatient stays (§§ 456.134 through 456.135).

Under both processes, all federally required beneficiary information must be included to approve and process claims for acute care inpatient services. Medi-Cal Consultants also safeguard all patient related information by working collaboratively with providers, counties, business associates, and other state agencies to safeguard Protected Health Information and Personally Identifiable Information.

This includes entering into hospital agreements to access electronic medical and health records. Providers are also required to protect patient confidentiality for records in multiple ways. At the time of Medi-Cal program enrollment, providers agree to adhere to federal and state statutes and regulations related to protecting confidential patient information.

These requirements for participation in the Medi-Cal program are set forth in the SSA (United States Code, Title 42, Chapter 7); the CFR, Title 42; the WIC, Division 9, Part 3, Chapter 7, and the regulations contained in the CCR, Title 22, Division 3, Subdivision 1.

As a participant in the TAR-Free process, **hospitals** are required to provide a process for resolving Medi-Cal beneficiary grievances including recording of all grievances received, date of receipt, nature of problem, date and resolution or disposition of the grievance. See TAR-Free Participation Agreements, Section V, Attachments 4 and 5 and Title 42, CFR, §§ 456.124 and 456.136. Hospital compliance is also required via statutes, regulations, and the Medi-Cal Provider Agreement (see above). State compliance is also required via statutes and regulations, i.e., pursuant to WIC § 10950 and Title 22 CCR §§ 50951 and 51014.1 related to State Fair Hearing rights, any action other than approval for an item or service, the state must notify a member of their right to a State Fair Hearing.

Medi-Cal Policy Review

DHCS Medi-Cal Consultants conduct comprehensive reviews of TARs to ensure that Medi-Cal policy is applied appropriately. Within the TAR-Free process, they may enhance a sample through focused reviews to ensure the correct implementation of Medi-Cal policy. For instance, a focused review could involve examining a subset of medical records for beneficiaries with restricted aid codes, with the purpose of verifying that the services for which the hospital submitted claims align precisely with the services covered by a beneficiary's aid code. Furthermore, the Medi-Cal Consultants ascertain that any emergency services claimed meet the criteria for medical necessity as defined by both state and federal regulations.

Additionally, the California Department of Public Health's (CDPH) Initial and Relicensing Surveys are on-site inspections that are conducted to ensure quality of care and compliance with state and federal laws and regulations. As the State Survey Agency for the CMS, CDPH ensures that facilities accepting Medicare and Medi-Cal payments meet federal requirements, including those outlined in the Code of Federal Regulations (CFR), Title 42, Chapter IV, Subchapter G, Part 482, Conditions of Participation for Hospitals, §§ 482.1 through 482.104.

GACH Relicensing Surveys are conducted no less than every three years, and more often when necessary. CDPH certifies GACH compliance with these and other federal requirements using the Form CMS-1539 to document survey findings and certification actions. These surveys ensure that hospitals have a governing body, organized medical staff, and established medical staff by-laws, rules, and regulations that address the provision of GACH activities.

Attachments

1. Approaches to Acute Inpatient Services Utilization Review, TAR & TAR-Free Processes
2. SSW Historical Timeline: Utilization Review Approach & Payment Method
3. Comparison of the 2024-2026 SSW UR Processes to the Requirements of CFR, Title 42, Part 456, Utilization Control, Subpart C, Utilization Control: Hospitals, §§ 456.50 through 456.145
4. DPH TAR-Free Participation Agreement
5. NDPH and Private Hospital TAR-Free Participation Agreement