STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

INCREASE IN MEDICAID PAYMENT AMOUNTS FOR CALIFORNIA DISPROPORTIONATE SHARE HOSPITALS

This segment of the State Plan sets forth the manner in which Medi-Cal payments for acute inpatient hospital services take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs, as required by Sections 1396a(a)(13)(A) and 1396r-4 of Title 42 of the United States Code.

A. Disproportionate Share Hospitals

1. Hospitals shall be deemed disproportionate share hospitals if for a calendar year ending 18 months prior to the beginning of a particular State fiscal year:

   a. the hospital's Medicaid inpatient utilization rate as defined in Section 1396r-4(b)(2) of Title 42 of the United States Code and computed pursuant to pages 30-37B of this Attachment 4.19-A, is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or

   b. the hospital's low income inpatient utilization rate as defined in Section 1396r-4(b)(3) of Title 42 of the United States Code and computed pursuant to pages 30-37B of this Attachment 4.19-A, exceeds 25 percent;

   and in each case,

   c. the hospital has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the U.S. Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This requirement does not apply to a hospital (1) the inpatients of which are predominantly individuals under 18 years of age; or (2) which does not offer non-emergency obstetric procedures as of December 22, 1987; and

   d. the hospital's Medicaid inpatient utilization rate, as computed under paragraph a, above, is at least one percent.

2. A hospital will be considered to have disproportionate share hospital status regardless of whether it meets the requirements set forth in paragraphs A.1.a and A.1.b, above, if, during the payment adjustment year, the hospital is licensed to

the University of California and meets the requirements set forth in paragraphs A.1.c and A.1.d, above.

3. With respect to those disproportionate share hospitals that meet the requirements of subsection A.1 which are non-government operated hospitals, that is, hospitals that are licensed to entities *other than* a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state, the requirements of Sections 1396a(a)(13)(A) and 1396r-4 of Title 42 of the United States Code shall be satisfied through the provision of payment adjustments as described in paragraphs a and b below. The hospitals described in this subsection will not be eligible for payment adjustments provided for in Sections D through F below.

   a. An amount totaling **[one-hundred sixty dollars]** (**$ [160.00]**) will be paid as disproportionate share hospital payment adjustments to hospitals described in this subsection. The federal share of these payment adjustments will be subject to and drawn against the federal DSH allotment described in Section 1396r-4(f) of Title 42 of the United States Code.

   b. Each hospital described in this subsection shall receive a proportionate share of the total amount established in paragraph a, relative to the amounts calculated for the hospital pursuant to Appendix 2 to this Attachment 4.19-A. The proportionate share for each hospital meeting all other program requirements shall in no case be zero. Notwithstanding the provisions of Appendix 2, the amounts calculated thereunder for such hospitals are used solely for the determination of each hospital's proportionate share of disproportionate share hospital payment adjustments established under this subsection.

B. Definitions

The following definitions apply for purposes of this segment of Attachment 4.19-A.

1. "Disproportionate share list" means an annual list of disproportionate share hospitals that provide acute inpatient services that is issued by the State in tentative and final form with respect to the subject payment adjustment year, for purposes of this segment of Attachment 4.19-A.

2. "DSH" means disproportionate share hospital.

3. "Eligible hospital" or "eligible disproportionate share hospital" means a hospital that is eligible, pursuant to Section C, below, to receive payment adjustments with respect to the subject payment adjustment year.

4. "Government-operated hospital" means a hospital that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

5. "High DSH facility" or "high DSH status" means a government-operated hospital that is an eligible hospital that meets the criteria set forth in paragraph A.I.a or A.l.b, pursuant to Section I396r-4(g)(2)(B) of Title 42 of the United States Code and Section 4721(e) of the Balanced Budget Act of 1997 (P.L. No. 105-33), as amended by Section 607(a)(3) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into the Omnibus Consolidated Appropriations Act, 2000 (P.L. No. 106-112).

6. "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the California Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

7. "Payment adjustment" or "payment adjustment amount" means an amount paid or payable pursuant to Sections D through F, below, for acute inpatient hospital services provided by an eligible disproportionate share hospital.

8. "Payment adjustment year" means the state fiscal year (commencing July 1) with respect to which payment adjustments are to be made to eligible hospitals.

9. "Applicable federal fiscal year" means the federal fiscal year that commences on October 1 of the particular, or subject, payment adjustment year.

10. "Federal DSH allotment" means the maximum allotment of federal financial participation for DSH payment adjustments for California, as determined under Section 1396r-4(f) of Title 42 of the United States Code, for the applicable federal fiscal year.

11. "Finalized Medi-Cal 2552-10 cost report" means 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).

12. "Filed Medi-Cal 2552-10 cost report" means 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.

13. "OBRA 1993 limit" means the hospital-specific limitation on the total annual amount of DSH payment adjustments to each eligible hospital that can be made with federal financial participation under the provisions of Section l 396r-4(g) of Title 42 of the United States Code, as implemented pursuant to Section F, below.

14. "Uninsured individuals" means individuals with no source of third party insurance coverage for the hospital services they receive.
15. "Demonstration funding" means Medicaid funding for medical care services rendered to uninsured individuals, which is in addition to DSH payment adjustments, that is made available under the terms and conditions of a federal Medicaid demonstration project authorized by Section 1115(a) of the Social Security Act.

C. Eligibility For Disproportionate Share Hospital Payment Adjustments

1. Disproportionate share hospitals, as determined under subsections A.l and A.2, that are government-operated hospitals shall be eligible to receive payment adjustments provided for under Sections D through F, below.
2. The eligible hospitals described in subsection C.l will be categorized into one of the following DSH groups:
   a. Cost-based DSH facilities - government-operated hospitals eligible for reimbursement of inpatient hospital services pursuant to page 46 et seq. of this Attachment 4.19-A, as specified in Appendix 1 to this Attachment, and any other government-operated hospitals receiving approval of the Centers for Medicare & Medicaid Services. A hospital added to Appendix 1 after the start of a DSH payment adjustment year and before any DSH payments pertaining to that payment adjustment year have been issued will be treated as a cost-based DSH facility effective with the entire DSH payment adjustment year. However, for a hospital added to Appendix 1 in this scenario, for the purpose of paragraph D.2.b of this section, only costs for the partial period effective with the date the hospital is added to Appendix 1 can be included. A hospital added to Appendix 1 after the start of a DSH payment adjustment year and after any DSH payments pertaining to that payment adjustment year have been issued will continue to be paid DSH or DSH Replacement payments as a non-cost based DSH facility or private hospital, as applicable, for the remainder of that payment adjustment year and will be treated as a cost-based DSH facility effective with the beginning of the next DSH payment adjustment year.
   b. Non cost-based DSH facilities - government-operated hospitals that do not meet the description set forth in paragraph C.2.a, above.

D. Disproportionate Share Hospital Payment Adjustments

l. Payment adjustments for non-cost-based DSH facilities shall be determined as follows:
   a. For each subject payment adjustment year, the State will continue to perform all computations pursuant to the DSH provisions of the State Plan in effect as of the 2004-05 payment adjustment year, set forth in Appendix 2 to this Attachment 4.19-A ("the prior DSH methodology"). The State will use all data that would have been applicable for the subject payment adjustment year as if the prior DSH methodology was in effect for that year. The resulting determinations shall be used for purposes of the calculations set forth below.
   b. For each individual non cost-based DSH facility, the State will determine the sum of the hospital's non-supplemental payment adjustment amount pursuant to subsection P.2 of the prior DSH methodology, and the hospital's supplemental lump-sum payment adjustment amount pursuant to subsection P.3 of the prior DSH methodology.

c. For all hospitals meeting the definition of a public hospital eligible under the prior DSH methodology, the State will determine the aggregate total of the non-supplemental payment adjustment amounts pursuant to subsection P.2 of the prior DSH methodology, and the supplemental lump-sum payment adjustment amounts pursuant to subsection P.3 of the prior DSH methodology.

d. For each non cost-based DSH facility, the individual sum for the hospital determined under paragraph D.1.b will be divided by the aggregate public hospitals total determined under paragraph D.1.c. The resulting fraction shall be used for purposes of paragraph D.1.i, below.

e. For all hospitals meeting the definition of a nonpublic/converted hospital, a converted hospital or a nonpublic hospital eligible under the prior DSH methodology, the State will determine the aggregate total of the non-supplemental payment adjustment amounts pursuant to subsection P.2 of the prior DSH methodology, and the supplemental lump-sum payment adjustment amounts pursuant to subsection P.3 of the prior DSH methodology.

f. The aggregate public hospitals total determined under paragraph c. shall be added to the aggregate total for the nonpublic/converted hospitals, converted hospitals and nonpublic hospitals determined under paragraph D.1.e.

g. The State will determine that fraction which is the number 1.00, minus the federal medical assistance percentage, expressed as a fraction, that is applicable for federal financial participation purposes for the applicable federal fiscal year. The resulting fraction shall be used for purposes of paragraph D.1.h, below.

h. The total sum determined under paragraph f. shall be multiplied by the fraction determined under paragraph g. The product shall be increased by the amount of $85,000,000, and the resulting amount used for purposes of paragraph D1.i, below.

i. For each non cost-based DSH facility, the individual fraction for the hospital determined under paragraph D.1.d will be multiplied by the amount determined under paragraph D.1.h. The resulting product shall be subtracted from the individual sum for the hospital determined under paragraph D.1.b, yielding the maximum DSH payment adjustment amount for the hospital for the subject payment adjustment year.

j. Commencing October 1 of each payment adjustment year, the State will make interim distributions of payment adjustment amounts to the non

cost-based DSH facilities, which will be subject to interim and final adjustments as may be necessary.

k. Payment adjustments under this subsection will be subject to the OBRA 1993 hospital-specific DSH limits determined in Appendix 2, Subsection J and applied pursuant to Paragraph F below.

2. Payment adjustments for cost-based DSH facilities will be of one or both of the following types:

a. Direct DSH payments - these payments are available only to cost-based DSH facilities that meet the requirements for high DSH status. Direct DSH payments will be paid to hospitals in amounts as determined by the State, but in no event shall the payment to a hospital exceed an amount equal to 75% of the hospital's uncompensated care costs, as determined under Section E. below. These payments will be made on an interim basis, commencing October 1 of the subject payment adjustment year, subject to interim and final adjustments as may be necessary.

b. Cost-based DSH claims - the State will claim amounts from the federal DSH allotment based on hospital cost data for the state fiscal year in which the federal fiscal year commences, as determined under Section E, below.

(1) The total amount of the federal DSH allotment to be claimed under this paragraph for the subject payment adjustment year, in combination with that portion of the federal DSH allotment associated with the payment adjustments described under subsection A.3, payments to non cost-based DSH facilities under subsection D. 1, and the direct DSH payments under paragraph D.2.a for the subject payment adjustment year, will not exceed the federal DSH allotment.

(2) The State will determine the amount to be claimed from the costs of each cost-based DSH facility, but no such claim, in combination with the payments received by the hospital under paragraph D.2.a, will exceed the OBRA 1993 DSH limit for that hospital, as determined under Section F, below.

(3) Once claimed and received by the State, the amounts received will be distributed to hospitals in amounts as determined by the State. Interim distributions will be made from the amounts that are made available on the basis of the interim determinations of uncompensated care costs described in subsection E. 1, below. The State will make subsequent adjustments to the distribution amounts as may be necessitated by any interim and final reconciliations that

affect the total amount available for distribution. Amounts distributed to the hospitals pursuant to this subparagraph will not be used for determining compliance with the OBRA 1993 DSH limit; the OBRA 1993 DSH limit for each hospital will be determined in accordance with subparagraph D.2.b(2), above.

3. The federal DSH allotment will be applied with respect to the payment adjustments that are made for the subject payment adjustment year as described in subsections D.1 and D.2. For purposes of determining compliance with the federal DSH allotment, the costs incurred during the state fiscal year that are used to establish the cost-based DSH claims will be deemed to be payment adjustments for the period October 1 through June 30 of the applicable federal fiscal year.

E. Methodology for Determining Hospital Uncompensated Care Costs

Each eligible hospital's Medi-Cal 2552-10 cost report will be the basis for determining the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs. The determinations will be used for purposes of establishing and applying the OBRA 1993 limit described in Section F, below, and, with respect to cost-based DSH facilities, for purposes of establishing the cost based DSH claims that will be made by the State.

1. Interim Determination of Uncompensated Care Costs

a. Using the hospital's most recently filed Medi-Cal 2552-10 cost report and auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges), the cost report apportionment process as prescribed in the Worksheet D series will be applied to compute the hospital's interim uncompensated care costs. This data will be submitted to the State. The data must be from the period which corresponds to the most recently filed Medi-Cal cost report.

b. 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 all of the apportionment processes described in this Section E. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

c. On the Medi-Cal 2552-10 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26. 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) for the Worksheet C computation of cost-to-charge ratios. 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.

d. For hospitals that remove 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 2552-10 worksheets) to account for inpatient dental services. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

e. All applicable Medicaid inpatient and outpatient hospital revenues, and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed inpatient and outpatient hospital cost above to arrive at the hospital's total interim uncompensated care costs (except as otherwise provided in section F.1.c below). Payments, funding and subsidies made by a state or a unit of local government will not be offset (e.g., state-only, local-only or state- local health programs). The revenue and payment data will relate to services rendered during the period that corresponds to that of the Medi-Cal cost report upon which the inpatient and outpatient hospital cost determination is based.

f. The interim uncompensated care costs computed above will be trended to current year based on Market Basket update factor(s) or other approved hospital-related indices as approved by CMS. The interim uncompensated care costs may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1) Inpatient and outpatient hospital costs not reflected on the filed Medi-Cal 2552-10 cost report from which the interim uncompensated care costs are developed, but which would be incurred and reflected on the Medi-Cal 2552-10 cost report for the current year.

(2) Inpatient and outpatient hospital costs incurred and reflected in the filed Medi-Cal 2552-10 cost report from which the interim uncompensated care costs are developed, but which would not be

incurred or reflected on the Medi-Cal 2552-10 cost report for the current year.

Such costs must be properly documented by the hospital, and are subject to review by the State and CMS.

g. The interim uncompensated care costs determined under this subsection E.1 will not include any of the hospital's expenditures for which demonstration funding is or will be claimed for the provision of inpatient hospital and outpatient hospital services to uninsured patients for the subject payment adjustment year. Accordingly, the uncompensated care costs that are used to claim demonstration funding will be considered Medicaid revenue for purposes of subsection E.l, but the payment amounts actually received by the hospitals will not.

h. The State may apply an audit factor to the filed Medi-Cal 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 2552-10 cost reporting periods for which final determinations have been made. The State will identify such percentage to CMS.

2. Interim Reconciliation of Uncompensated Care Costs

a. Each eligible hospital's interim uncompensated care costs will be reconciled based on its filed Medi-Cal 2552-10 cost report for the subject payment adjustment year.

b. The hospital's total uncompensated care costs shall be determined using the filed Medi-Cal 2552-10 cost report and applying the steps set forth in paragraphs E.l.a through E.1.e, and paragraphs E.1.g. and E.1.h, above.

3. Final Reconciliation of Uncompensated Care Costs

a. Each eligible hospital's interim uncompensated care costs (and any interim adjustments) will be reconciled based on its finalized Medi-Cal 2552-10 cost report for the subject payment adjustment year.

b. The hospital's total uncompensated care costs shall be determined using the finalized Medi-Cal 2552-10 cost report and applying the steps set forth in paragraphs E.1.a through E.l.e, and paragraph E.1.g., above.

F. Computation of OBRA 1993 Hospital-Specific DSH Limits

Federal financial participation is available only for DSH funding amounts claimed by the State that do not exceed the OBRA 1993 hospital-specific limits established by 42 U.S.C. §1396r-4(g).

1. With respect to each eligible hospital, the determination of the OBRA 1993 limit shall be as follows:

   a. The OBRA 1993 limit shall be based upon each hospital's uncompensated care costs that are determined in accordance with Section E above (for cost-based hospitals) and Appendix 2, Section J (for non-cost based governmental hospitals and non-governmental hospitals) for the applicable payment adjustment year. Except as provided in paragraph b, the hospital's OBRA 1993 limit shall be 100% of its uncompensated care costs.

   b. For those eligible hospitals that are high DSH facilities the OBRA 1993 limits shall be 175% of the hospital's uncompensated care costs determined for the payment adjustment year. For the 2005-06 and 2006-07 payment adjustment years, a high DSH facility's expenditures for the provision of inpatient and outpatient hospital services to uninsured patients for which demonstration funding is claimed by the State will not be excluded from uncompensated care costs for purposes of determining the hospital's OBRA 1993 limit.

   c. Effective October 1, 2021, when determining the OBRA 1993 limit for cost-based hospitals in Section E above as well as for non-cost-based governmental hospitals and non-governmental hospitals based on Appendix 2, Section J, the OBRA 1993 limit will follow the definition of the hospital-specific limit and any applicable exceptions, pursuant to Section 1923(g) of the Social Security Act as amended by the Consolidated Appropriations Act, 2021.

2. With respect to each hospital that is a non cost-based DSH facility, for each payment adjustment year the sum of the payments made to the hospital under subsection D. 1 shall not exceed the OBRA 1993 limit determined for the hospital under subsection F. 1, above.

3. With respect to each hospital that is a cost-based DSH facility, for each payment adjustment year the sum of the direct DSH payments made to the hospital under paragraph D.2.a, plus the amount of the hospital's uncompensated care costs for which the State made cost-based DSH claims from the federal DSH allotment, shall not exceed the OBRA 1993 limit determined for the hospital under subsection F. 1, above.

G. Yearly Reporting and Auditing of DSH Program

In order to qualify for continued federal funding, and satisfy the requirements of Sections 1923(a) (2) (D) and 1923(j) (1) and (2) of the Social Security Act (hereafter "the Act"), the Department will submit an annual, independent certified audit, as required by 42 CFR 455.304(a) and (b), supplemented by a report as detailed in 42 CFR 447.299(c).

1. The State will submit an annual, independent certified audit, and a separate report, as detailed in item 2 below, beginning with State plan rate year 2005. Each audit report must be submitted to CMS within 90 days of the completion of the independent certified audit. Each audit report is due no later than December 31st of the FFY ending three years after the Medicaid State plan rate year under audit.

2. In the annual, independent certified audit, the auditor will verify whether the State's method of computing the hospital-specific DSH limit and the DSH payments made to the hospital comply with Section 1923(j) (2) of the Act. In the separate report, the State will provide the data elements needed to satisfy the requirements of Section 1923(j) (1) of the Act.

3. Beginning with Medicaid State Plan rate year 2011, provider overpayments (those DSH payments that exceed hospital-specific cost limits) identified in the audit process will be redistributed to other qualifying hospitals whose DSH payments are below their individual final hospital-specific DSH limits. DSH overpayments will be redistributed to all other qualified hospitals within each group (cost-based hospitals, non-cost-based governmental hospitals, and non-governmental hospitals), on a pro rata basis, using each hospital's final total DSH payment for the audit year in question.

Final List of DSH Eligible Hospitals for SFY 2005-06	OSHPD FACILITY ID
Designated Public Hospitals	**22 hospitals**
ALAMEDA COUNTY MEDICAL CENTER-HIGHLAND CAMPUS	10846
ARROWHEAD REGIONAL MEDICAL CENTER	364231
CONTRA COSTA REGIONAL MEDICAL CENTER	70924
KERN MEDICAL CENTER	150736
L.A. CO. HARBOR/UCLA MEDICAL CENTER	191227
L.A. CO. MARTIN LUTHER KING JR/DREW MED CTR	191230
L.A. CO. OLIVE VIEW MEDICAL CENTER	191231
L.A. CO. RANCHO LOS AMIGOS NATIONAL REHAB. CTR.	191306
L.A. CO. U.S.C. MEDICAL CENTER	191228
NATIVIDAD MEDICAL CENTER	274043
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	334487
SAN FRANCISCO GENERAL HOSPITAL	380939
SAN JOAQUIN GENERAL HOSPITAL	391010
SAN MATEO COUNTY GENERAL HOSPITAL	410782
SANTA CLARA VALLEY MEDICAL CENTER	430883
TUOLUMNE GENERAL HOSPITAL	551061
UNIV OF CALIF DAVIS MEDICAL CENTER	341006
UNIV OF CALIF IRVINE MEDICAL CENTER	301279
UNIV OF CALIF LOS ANGELES MEDICAL CENTER/SANTA MONICA	190796
UNIV OF CALIF SAN DIEGO MEDICAL CENTER	370782
UNIV OF CALIF SAN FRANCISCO MEDICAL CENTER	381154
VENTURA COUNTY MEDICAL CENTER	560481
Non-Designated Public Hospital	**30 Hospitals**
ANTELOPE VALLEY HOSPITAL MEDICAL CENTER	190034
BEAR VALLEY COMMUNITY HOSPITAL	361110
COALINGA REGIONAL MEDICAL CENTER	100697
EASTERN PLUMAS HEALTH CARE	320859
EL CENTRO REGIONAL MEDICAL CENTER	130699
FRESNO COUNTY PSYCHIATRIC HEALTH FACILITY	104089
HI-DESERT MEDICAL CENTER	362041
INDIAN VALLEY DISTRICT HOSPITAL	320874
JEROLD PHELPS COMMUNITY HOSPITAL	121031
JOHN C. FREMONT HEALTHCARE DISTRICT	220733
KERN VALLEY HEALTHCARE DISTRICT	150737
KINGSBURG MEDICAL CENTER	100745
LOMPOC DISTRICT HOSPITAL	420491
MAYERS MEMORIAL HOSPITAL	450936
MODOC MEDICAL CENTER	250956
MORENO VALLEY COMMUNITY HOSPITAL	334048
MOUNTAINS COMMUNITY HOSPITAL	361266
OAK VALLEY DISTRICT HOSPITAL	500967
PIONEERS MEMORIAL HOSPITAL	130760
SAN LUIS OBISPO COUNTY P.H.F.	404046
SANTA BARBARA P.H.F.	424002
SEMPERVIRENS PSYCHIATRIC HEALTH FACILITY	124004
SHASTA COUNTY PSYCHIATRIC HEALTH FACILITY	451019
SIERRA KINGS DISTRICT HOSPITAL	100797
SIERRA VIEW DISTRICT HOSPITAL	540798
SOUTHERN INYO HOSPITAL	141338
SURPRISE VALLEY COMMUNITY HOSPITAL	250955
UCLA NEUROPSYCHIATRIC HOSPITAL	190930
TRINITY HOSPITAL	531059
TULARE DISTRICT HOSPITAL	540816

Final List of DSH Eligible Hospitals for SFY 2005-06	OSHPD FACILITY ID
Private Hospitals	**103 Hospitals**
ALHAMBRA HOSPITAL MEDICAL CENTER	190017
ANAHEIM GENERAL HOSPITAL	301097
AURORA CHARTER OAK	190163
BELLFLOWER MEDICAL CENTER	190066
BEVERLY HOSPITAL	190081
BHC ALHAMBRA HOSPITAL	190020
CALIFORNIA HOSPITAL MEDICAL CENTER OF L.A.	190125
CALIFORNIA SPECIALTY HOSPITAL	481015
CANYON RIDGE HOSPITAL	364050
CENTRAL VALLEY GENERAL HOSPITAL	160787
CHILDREN'S HOSP. & RESEARCH CTR. AT OAKLAND	10776
CHILDREN'S HOSPITAL - SAN DIEGO	370673
CHILDREN'S HOSPITAL CENTRAL CALIFORNIA	204019
CHILDRENS HOSPITAL OF LOS ANGELES	190170
CHILDREN'S HOSPITAL OF ORANGE COUNTY	300032
CHINO VALLEY MEDICAL CENTER	361144
CITRUS VALLEY MEDICAL CENTER-QV CAMPUS	190636
CITY OF ANGELS MEDICAL CENTER-DOWNTOWN CAMPUS	190661
CITY OF HOPE NATIONAL MEDICAL CENTER	190176
COASTAL COMMUNITIES HOSPITAL	301258
COLLEGE HOSPITAL	190184
COLLEGE HOSPITAL COSTA MESA	301155
COMMUNITY & MISSION HOSP. OF HUNTINGTON PARK-SLAUS	190197
COMMUNITY HOSPITAL OF SAN BERNARDINO	361323
COMMUNITY MEDICAL CENTER-FRESNO	100717
DANIEL FREEMAN MEMORIAL HOSPITAL	190230
DELANO REGIONAL MEDICAL CENTER	150706
DOCTOR'S HOSPITAL MEDICAL CENTER OF MONTCLAIR	361166
DOCTORS HOSPITAL OF WEST COVINA	190857
DOCTORS MEDICAL CENTER OF MODESTO	500852
EARL & LORAINE MILLER CHILDREN'S HOSPITAL	196168
EAST LOS ANGELES DOCTOR'S HOSPITAL	190256
EAST VALLEY HOSPITAL MEDICAL CENTER	190328
ELASTAR COMMUNITY HOSPITAL	190685
FOUNTAIN VALLEY REGIONAL HOSP. & MED. CTR.-EUCLID	301175
FREMONT HOSPITAL	14034
GARDEN GROVE HOSPITAL & MEDICAL CENTER	301283
GARFIELD MEDICAL CENTER	190315
GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER	190317
GEORGE L. MEE MEMORIAL HOSPITAL	270777
GOOD SAMARITAN HOSPITAL OF BAKERSFIELD	150775
GREATER EL MONTE COMMUNITY HOSPITAL	190352
HEALTHBRIDGE CHILDREN'S HOSPITAL-ORANGE	304159
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD	190380
JOHN F. KENNEDY MEMORIAL HOSPITAL	331216
KEDREN COMMUNITY MENTAL HEALTH CENTER	190150
LINCOLN HOSPITAL MEDICAL CENTER	190468
LITTLE COMPANY OF MARY/SAN PEDRO HOSPITAL	190680
LOMA LINDA UNIVERSITY MEDICAL CENTER	361246
LONG BEACH MEMORIAL MEDICAL CENTER	190525

Final List of DSH Eligible Hospitals for SFY 2005-06	OSHPD FACILITY ID
LOS ANGELES COMMUNITY HOSPITAL	190198
LOS ANGELES METROPOLITAN MEDICAL CENTER	190854
MADERA COMMUNITY HOSPITAL	201281
MEMORIAL HOSPITAL OF GARDENA	190521
MERCY HOSPITAL OF MT. SHASTA	470871
MERCY MEDICAL CENTER - MERCED	240942
MERCY WESTSIDE HOSPITAL	150830
METHODIST HOSPITAL OF SACRAMENTO	340951
MISSION COMMUNITY HOSPITAL OF PANORAMA	190524
MODESTO REHABILITATION HOSPITAL	500954
MONTEREY PARK HOSPITAL	190547
NORTH BAY MEDICAL CENTER	481357
NORTHRIDGE HOSPITAL MEDICAL CENTER - SHERMAN WAY	190810
OJAI VALLEY COMMUNITY HOSPITAL	560501
OROVILLE HOSPITAL	40937
ORTHOPAEDIC HOSPITAL	190581
PACIFIC ALLIANCE MEDICAL CENTER	190307
PACIFIC HOSPITAL OF LONG BEACH	190587
PACIFICA HOSPITAL OF THE VALLEY	190696
PALO VERDE HOSPITAL	331288
PARADISE VALLEY HOSPITAL	370759
PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER	331293
POMONA VALLEY HOSPITAL MEDICAL CENTER	190630
PROVIDENCE HOLY CROSS MEDICAL CENTER	190385
QUEEN OF ANGELS/HOLLYWOOD PRESBYTERIAN MED. CTR.	190382
REDBUD COMMUNITY HOSPITAL	171049
REGIONAL MEDICAL OF SAN JOSE	430705
ROBERT F. KENNEDY MEDICAL CENTER	190366
SAN VICENTE HOSPITAL	190681
SANTA ANA HOSPITAL MEDICAL CENTER	301314
SCRIPPS MERCY HOSPITAL	370744
SELMA COMMUNITY HOSPITAL	100793
SHARP CORONADO HOSPITAL & HEALTHCARE CENTER	370689
SHARP MARY BIRCH HOSPITAL FOR WOMEN	370695
ST. DOMINIC'S HOSPITAL	394009
ST. FRANCIS MEDICAL CENTER	190754
ST. JOSEPH HOSPITAL OF EUREKA	121080
ST. LUKE'S HOSPITAL	380964
ST. MARY MEDICAL CENTER	190053
ST. ROSE HOSPITAL	10967
SUBURBAN MEDICAL CENTER	190599
SUTTER MEDICAL CENTER OF SANTA ROSA	490919
SUTTER SOLANO MEDICAL CENTER	481094
TELECARE SOLANO PSYCHIATRIC HEALTH FACILITY	484028
TUSTIN HOSPITAL MEDICAL CENTER	301357
UKIAH VALLEY MEDICAL CENTER - HOSPITAL DR.	231396
UNIVERSITY COMMUNITY MEDICAL CENTER	370787
VALLEY PRESBYTERIAN HOSPITAL	190812
VICTOR VALLEY COMMUNITY HOSPITAL	361370
WESTERN MEDICAL CENTER - ANAHEIM	301188
WESTERN MEDICAL CENTER OF SANTA ANA	301566
WHITE MEMORIAL MEDICAL CENTER	190878
WHITTIER HOSPITAL MEDICAL CENTER	190883
Total Number of Hospitals	**156**

*Highlighted Hospitals were not on the 0405 List.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

PRIVATE DISPROPORTIONATE SHARE HOSPITAL REPLACEMENT SUPPLEMENTAL PAYMENTS

Federal financial participation (FFP) for Disproportionate Share Hospital (DSH) Replacement supplemental payments to eligible private hospitals was initially authorized pursuant to California's Section 1115 demonstration project entitled "Medi-Cal Hospital/ Uninsured Care" (No. 11-W-00193/9), effective September 1, 2005 through October 31, 2010, and subsequently authorized pursuant to the successor project entitled "California Bridge to Reform Demonstration" (No. 11-W-00193/9), effective November 1, 2010 through December 31, 2015. This amendment will continue the prior demonstration-based authority under the State Plan to allow for receipt of FFP for DSH Replacement supplemental payments made to eligible private hospitals, effective January 1, 2016.

DSH Replacement payments are fee-for-service inpatient hospital supplemental payments, and are subject to the private hospital upper payment limit as defined in 42 CFR 447.272. As such, DSH Replacement supplemental payments shall not be considered payments made under Section 1923 and shall not be charged against California's federal DSH allotment for an applicable federal fiscal year as described in Section 1923(f).

DSH Replacement Supplemental payments are available for private hospitals identified on the State's disproportionate share list issued by the Department for the project year, and shall be calculated pursuant to the DSH provisions of the State Plan in effect as of the 2004-05 payment adjustment year, set forth in Appendix 2 to this Attachment 4.19-A (entitled the "prior DSH methodology"). The calculation will take into account applicable changes to the OBRA 1993 limit, effective October 1, 2021, pursuant to Section 1923(g) of the Social Security Act, as amended by the Consolidated Appropriations Act, 2021.

A. DSH REPLACEMENT SUPPLEMENTAL PAYMENT CALCULATION AND DISTRIBUTION

1. Interim payments shall be made for the first five months of each project year in the following manner:

    a. Interim payments shall be made to private hospitals identified on the tentative DSH list for the project year provided that the private hospital was also on the final DSH list for the prior project year. The amount of the monthly interim payments shall be equal to one-twelfth of the total payments, based on the private hospital's prior project year payments. "Tentative DSH list" means a draft list of the current project year's DSH-eligible hospitals sent to stakeholders and hospitals for review and confirmation of the hospital's MIUR

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

PRIVATE DISPROPORTIONATE SHARE HOSPITAL REPLACEMENT SUPPLEMENTAL PAYMENTS

and LIUR data used to determine a hospital's eligibility status. "Final DSH list" means a finalized list of hospitals determined DSH eligible, after any necessary corrections or adjustments are made to the eligibility data.

b. The Department shall make the first interim payment for a project year to each eligible private hospital no later than 60 days after the issuance of the tentative DSH list for the project year and shall include the interim payment amount for all prior months in the project year. These monthly interim payments will be made no earlier than the quarter ending December 31 of each project year.

2. Tentative adjusted monthly payments shall be made for the months of December through March of each project year to each eligible private hospital identified on the final DSH list for the project year and paid as follows:

   a. The Department shall compute an adjusted payment amount for each eligible private hospital in accordance with Attachment 4.19-A, Appendix 2, page 29ffff, paragraph P.

   b. The Department shall compute a tentative adjusted monthly payment amount for each eligible private hospital. The amount shall be equal to the adjusted payment amount for the hospital minus the aggregate interim payments made to the hospital for the project year divided by seven.

   c. The Department will make the first tentative adjusted monthly payment for a project year to each eligible private hospital by January 15, or within 60 days after the issuance of the final DSH list for a project year, whichever of these dates is later. This payment amount shall include the tentative adjusted monthly payment amounts for all prior months in the project year for which those payments are due. These monthly tentative adjusted payments will be made no earlier than the quarter ending March 31 of each project year.

3. Final adjusted total payments shall be paid to each private hospital identified on the final DSH list in the following manner:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

SUPPLEMENTAL REIMBURSEMENT FOR QUALIFIED PRIVATE HOSPITALS

a. Eligible private hospitals identified on the final DSH list for the project year shall receive three final adjusted payment amounts for the months of April through June of the project year. These payments shall be computed and paid as follows:

   i. The Department shall compute an annual final data adjusted payment amount for each eligible hospital in accordance with paragraph P of Appendix 2 to this Attachment 4.19-A (entitled the "prior DSH methodology"). This payment amount shall reflect data corrections, hospital closures and any other revisions made by the Department after the issuance of the tentative adjusted monthly payments.

   ii. The Department shall compute a monthly final data adjusted payment amount for each eligible private hospital. This amount shall be equal to the annual final data adjusted payment amount for the hospital minus both the aggregate interim payments made to the hospital for the project year and the aggregate tentative adjusted monthly payments made to the hospital divided by three. These monthly final data adjusted payments will be made no earlier than the quarter ending June 30 of each project year.

4.

The Department will complete the above payments, which are based on preliminary FY federal Disproportionate Share Hospital allotments issued by CMS, to all eligible private hospitals by June 30 of the next project year. After CMS releases the final FY federal Disproportionate Share Hospital allotment, the Department will recalculate as needed to determine recoupment or additional payments. Additional payments will be made within 90 days of the CMS release of the final FY federal Disproportionate Share Hospital allotment.

METHODS AND ASSUMPTIONS FOR DEFINING DISPROPORTIONATE SHARE HOSPITALS

A. Final Determination

The annual determination of disproportionate share status as shown on the disproportionate share list will be final (no retroactive changes will be made based on actual year of service data).

The following describes the determination, data, and the processes to be used in determining a hospital's status as a disproportionate share provider and the applicable payment adjustments.

All calculations are to be rounded to the nearest tenth of a percent.

B. Medicaid Inpatient Utilization Rate

(1) Individual Hospital Calculation

A hospital's Medicaid inpatient utilization rate shall be the quotient (expressed as a percentage) which results from dividing the number of the hospital's acute care inpatient days attributable to patients who (for such days) were eligible for medical assistance under this State Plan during a defined 12-month period by the total number of the hospital's inpatient days during the same time period. In calculations involving Medicaid Inpatient Utilization Rates, this period is the most recent calendar year ending 18 months prior to the beginning of the payment adjustment year in question. For example, if disproportionality were being determined for the 1991-92 payment adjustment year, the defined period would be calendar year 1989.

To determine "Medicaid Days" the State shall total for each hospital the general acute care inpatient days, all nursery inpatient days, acute psychiatric inpatient days, and administrative days for the calendar year ending 18 months prior to the beginning of the payment adjustment year for which payment adjustments are required. These data are based on the Medi-Cal Month of Payment tapes created by the State's fiscal intermediary and

transmitted by the intermediary to the Department of Health Care Services. The acute psychiatric inpatient days provided to Medicaid eligible persons under the Short - Doyle/Medi- Cal program are taken from a separate file of the Medi- Cal Paid Claims System for the same calendar year. General acute care inpatient and acute psychiatric care inpatient days for Medicaid eligible persons paid by Health Insuring Organizations (HIO) are included in the calculations. When consistent and reliable data is available statewide as determined by the Department of Health Care Services, the Department may include general acute care inpatient and acute psychiatric care inpatient hospital days attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department to provide such services. Using the OSHPD statewide data base file for the calendar year ending 18 months prior to the beginning of the payment adjustment year for which payment adjustments are required, the number of Medicaid patient days for non-California Medicaid beneficiaries reported by each hospital is divided by the total number of Medicaid patient days reported by each hospital. The count of Medicaid patient days is based on discharge records which report that Medi- Cal (used synonymously with Title XIX) was the expected principal source of payment at the time of discharge. Acute care, psychiatric and rehabilitation care types of discharge records are included, while skilled nursing, intermediate care and non-acute alcohol/drug rehabilitation care discharge records are excluded from the calculation of the ratio. This ratio is then applied to each hospital's paid Medi-Cal days for the same period to estimate those Medicaid days which originate outside of the state. (It is noted that "Medicaid Days" does not include subacute care days and long term care days.)

To determine "Total Days" the State shall use data from the OSHPD statewide data base file for the calendar year ending 18 months prior to the beginning of the particular payment adjustment year. In calculating the actual number of "Total Days," the State shall add the general acute care inpatient days, all nursery inpatient days, acute psychiatric inpatient days, and administrative days in the Annual Report and shall subtract the patient days

for chemical dependency recovery services in licensed general acute patient beds and in licensed acute psychiatric care beds in the Annual report.

The specific formulae used to derive this percentage are as follows:

MEDICAID_ PERCENT = ((MEDICAID_DAYS/TOTAL_DAYS) *100)

WHERE:

MEDICAID DAYS = Total Paid Medicaid Days +
Est. Out of State Medicaid Patient Days

Total Paid Medicaid Days =
Medicaid GAC Days + Medicaid APC Days +
Medicaid-Nursery Days +
Medicaid-Short Doyle Days +
Medicaid Administrative Days

Estimated Out of State Medicaid Beneficiary Patient Days =
(Total Paid Medicaid Days *
(Out of State Medicaid Beneficiary Patient Days
/Total Medicaid Patient Days))

Total Medicaid Patient Days and
Out of State Medicaid Beneficiary Patient Days
are extracted directly from the OSHPD Discharge
Data Set and are as reported by the hospital.

TOTAL DAYS = Total GAC Days + Total APC Days +
Total Nursery Days +
Chem Dependency Days in GAC Beds -
Chem Dependency Days in APC Beds

GAC = General Acute Care
APC = Acute Psychiatric Care

The following arithmetic symbols are used:

+ addition
- (dash) subtraction
* multiplication
/ division

In addition, the symbol (underscore) is used to connect words that are part of variable names.

(2) Calculation of Mean and Standard Deviation of Medicaid Utilization Rate

The mean and one standard deviation above the mean of the Medicaid utilization rate shall be calculated based on data for all hospitals receiving Medicaid payments in the State for the calendar year period ending 18 months prior to the beginning of the particular payment adjustment year. These statistics shall be weighted by the total patient days in each hospital.

C. Low-Income Utilization Rate

A hospital's low-income utilization rate for a defined period of time shall be the sum of two fractions (expressed as a percentage) which consist of the factors described below. In calculations involving Low-Income Utilization Rates, this defined period varies by hospital and is taken as the hospital's fiscal time period which ends during the calendar year which ends 18 months prior to the beginning of the particular payment adjustment year. For example, if disproportionality were being examined for the State's fiscal year 1991/92, the OSHPD Annual Financial Disclosure Report for the time period which ends in calendar year 1989 would be used.

LOW_INCOME = MEDICAID + CHARITY

(1) Fraction Number 1 (MEDICAID)

The first fraction involves the total revenues paid to a hospital for patient services - including cash subsidies from State and local governments. The numerator of this fraction is the total amount of dollar revenue paid to a hospital for the defined 12 month period for patient services (Inpatient and Outpatient) under the State Plan plus any cash subsidies for patient services received directly from State and local governments. The denominator of this fraction is the total amount of dollars paid to a hospital (including the amount of such cash subsidies) minus the disproportionate share payments made pursuant to page 18 et seq. of this Attachment 4.19A for the same defined period

for all patient services.

For the first fraction, the numerator shall consist of the following items from the applicable OSHPD Annual Financial Disclosure Report, OSHPD Annual Patient Discharge Data and data collected by the Department of Health Services: Medi-Cal Net Patient Revenue (Inpatient and Outpatient), minus the absolute value of Disproportionate Share Payments for Medi-Cal Patient Days (if any), plus County Indigent Program Net Patient Revenue (Inpatient and Outpatient), (if any) plus Managed Care Program Net Inpatient Medi-Cal Revenue (if any) plus the absolute value of U.C. Gross Clinical Teaching Support (if any). The denominator shall consist of the following items from the applicable OSHPD Annual Financial Disclosure Report: Total Net Patient Revenue for all patients minus the absolute value of Disproportionate Share Payments for Medi-Cal Patient Days.

MEDICAID = 100[(MCLPDPRV + CSHTOSUB) / TOTPDPRV].

Where:

MCLPDPRV = Medi-Cal Paid Patient Revenue
= MCNETPRV - |DISPSHRE| + MCPNIPRV.

MCNETPRV = Medi-Cal Net Patient Revenue.
DISPSHRE = Disproportionate Share Payments for Medi-Cal Patient Days.
MCPNIPRV = Managed Care Program Net Inpatient Medi-Cal Revenue.

CSHTOSUB = Total Cash Subsidies from State and Local Government
= |UCCLTCHS| + CIPNPREV.

UCCLTCHS = U.C. Gross Clinical Teaching Support.

CIPNPREV = County Indigent Program Net Patient Revenue.

TOTPDPRV = Total Paid Patient Revenue
= TOTNETPR - |DISPSHRE|.

TOTNETPR = Total Net Patient Revenue.
DISPSHRE = Disproportionate Share Payments for Medi-Cal Patient Days.

(2) Fraction Number 2 (CHARITY)

The second fraction involves the total charges of a hospital for inpatient hospital services. The numerator of this fraction is the total amount of the hospital's charges for inpatient hospital services attributable to charity care less the portion of any state and local government cash subsidies reasonably attributable to inpatient hospital services. The denominator of this fraction is the total amount the hospital charges for inpatient hospital services in the hospital for the defined period.

In this fraction, the numerator shall be calculated with items from the applicable OSHPD Annual Financial Disclosure Report as follows:

(a) Total Other Inpatient Charity is the sum of County Indigent Program Gross Inpatient Revenue (if any), minus County Indigent Program Gross Inpatient Charity (if any), plus Gross Inpatient Charity (if any), minus Hill Burton Gross Inpatient Charity (if any), plus U.C. Gross Inpatient Teaching Allowances (if any), plus the absolute value of U.C. Gross Inpatient Clinical Teaching Support (if any). Gross Inpatient Charity is the sum of Non-Medi-Cal Gross Inpatient Charity (if any), plus Medi-Cal

Gross Inpatient Charity (if any). Medi-Cal Gross Inpatient Charity is calculated by multiplying Medi-Cal Gross Patient Charity (if any) by the ratio of Medi-Cal Gross Inpatient Revenue to Medi-Cal Gross Patient Revenue. Hill Burton Gross Inpatient Charity is calculated by multiplying Hill Burton Gross Patient Charity by the ratio of Gross Inpatient Charity to Gross Patient Charity. This results in an estimate of the amount of charity attributable to inpatient services.

(b) The Inpatient Portion of Total Cash Subsidies from State and Local Government is the sum of County Indigent Program Net Inpatient Revenue (if any), plus the absolute value of U.C. Gross Inpatient Clinical Teaching Support (if any). This results in an estimate of the amount of subsidies paid to inpatient charity services.

(c) The result of step (b) is subtracted from the result of step (a).

The denominator shall consist of Gross Inpatient Revenue extracted from the applicable OSHPD Annual Financial Disclosure Report.

Charity charges attributable to a hospital's Hill-Burton obligation are excluded from the calculation of low-income.

The numerator and denominator are expressed in detail as formulae below:

CHARITY = 100[(CHRIPOTH - CSHIPSUB) / GRINPREV].

Where:

CHRIPOTH = Total Other Inpatient Charity
= CIPGIPRV - CIPGIPCH + GRINPCHR - PCTIPCHR[HBGRPCHR] + UCIPTCAL + |UCIPCLTS|.

CIPGIPRV = County Indigent Program Gross Inpatient Revenue.
CIPGIPCH = County Indigent Program Gross Inpatient Charity.
GRINPCHR = Gross Inpatient Charity
= NMCINPCR + MCINPCHR.

NMCINPCR = Non-Medi-Cal Gross Inpatient Charity.
MCINPCHR = Medi-Cal Gross Inpatient Charity
= PCTMCIPR[MCGRPCHR].

PCTMCIPR = Medi-Cal Gross Inpatient Revenue as a Percentage of Medi-Cal Gross Patient Revenue
= MCGRIPRV / MCGRPTRV.

MCGRIPRV = Medi-Cal Gross Inpatient Revenue.
MCGRPTRV = Medi-Cal Gross Patient Revenue.

MCGRPCHR = Medi-Cal Gross Patient Charity.

PCTIPCHR = Gross Inpatient Charity as a Percentage of Gross Patient Charity
= GRINPCHR / GRPATCHR.

GRINPCHR = Gross Inpatient Charity (defined above).
GRPATCHR = Gross Patient Charity.

HBGRPCHR = Hill Burton Gross Patient Charity.
UCIPTCAL = U.C. Gross Inpatient Teaching Allowances.
UCIPCLTS = U.C. Gross Inpatient Clinical Teaching Support.

CSHIPSUB = Inpatient Portion of Total Cash Subsidies from State And Local Government
= |UCIPCLTS| + CIPNIPRV.

UCIPCLTS = U.C. Gross Inpatient Clinical Teaching Support.
CIPNIPRV = County Indigent Program Net Inpatient Revenue.

GRINPREV = Gross Inpatient Revenue.

(3) Data Sources Used in Determining Various Factors

Except as provided below, the Annual Financial Disclosure Report of a hospital submitted to OSHPD, as clarified by the data collected by the Department in accordance with subdivision (f) of Section 14105.98 of the Welfare and Institutions Code, shall be the source to determine the amounts of the various elements in fractions 1 and 2. The Annual Financial Disclosure Report of an individual hospital to be used for a particular payment adjustment year for which payment adjustments are required shall be that Report which covers the hospital's reporting fiscal time period which ends during the calendar year which ends 18 months prior to the beginning of the particular payment adjustment year. When consistent and reliable data are available, Annual OSHPD Patient Discharge Data and data collected by the Department of Health Services will be used as the data sources to determine inpatient hospital revenue attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department.