Citation | Condition or Requirement

REIMBURSEMENT OF PSYCHIATRIC INPATIENT HOSPITAL SERVICES
PROVIDED BY SHORT-DOYLE/MEDI-CAL HOSPITALS

Psychiatric inpatient hospital services will be provided as part of a comprehensive program that provides rehabilitative mental health and targeted case management services to Medicaid (Medi-Cal) beneficiaries that meet medical necessity criteria established by the State.

A. GENERAL APPLICABILITY

Short-Doyle Medi-Cal (SD/MC) Hospitals will be eligible to be reimbursed under this segment for the provision of Psychiatric Inpatient Hospital Services. Reimbursement will be based upon each hospital's reasonable and allowable cost as determined in the CMS 2552 hospital cost report and supplemental schedules or its usual and customary charge, whichever is lower, unless the hospital is a nominal charge hospital. Reimbursement of Psychiatric Inpatient Hospital Services provided by SD/MC hospitals that are nominal charge hospitals is based upon each hospital's reasonable and allowable cost as determined in the CMS 2552 hospital cost report and supplemental schedules.

B. DEFINITIONS

"Acute psychiatric inpatient hospital services" means those services provided by a hospital to beneficiaries for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.

"Administrative Day services" means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's needs for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

"Hospital-based ancillary services" means services other than routine hospital services and psychiatric inpatient hospital professional services that are received by a beneficiary admitted to a SD/MC hospital

"Nominal charge hospital" means a hospital with charges that are less than or equal to sixty percent of the reasonable and allowable cost of psychiatric inpatient hospital services.

"Psychiatric inpatient hospital services" means acute psychiatric inpatient hospital services and administrative day services provided by a SD/MC hospital, which are reimbursed a per diem rate that includes the cost of routine hospital services and all hospital based ancillary services.

"Reconciled cost report" mean the amended cost report filed by a hospital no later than eighteen months after the close of the fiscal year, which reconciles the days and charges reported in the cost report with the State's records pursuant to Section D.d of this segment.

"Reasonable and allowable cost means cost based on year-end CMS 2552 hospital cost reports and supplemental schedules; and Medicare principles of reimbursement as described at 42 CFR 413; the CMS Provider Reimbursement Manual, Publication 15-1; and other applicable federal directives that establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program.

"Routine hospital services" means bed, board, and all medical, nursing, and support services usually provided to an inpatient by a hospital. Routine services do not include hospital-based ancillary services, psychiatrist or other physician services, or psychologist services.

"Schedule of Maximum Interim Rates" means a statewide schedule of maximum rates per day that will be paid on an interim basis for acute psychiatric inpatient hospital services and administrative day services. These rates are updated and published annually.

"SD/MC hospitals" means hospitals that claim reimbursement for psychiatric inpatient hospital services through the SD/MC claiming system and are the hospitals listed on page 40.5 of this segment.

"Usual and Customary Charge" means the regular rates that providers charge both Medi-Cal beneficiaries and other paying patients for the services furnished to them (42 CFR 413.13).

C. PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Psychiatric Inpatient Hospital Services provided by SD/MC hospitals are both acute psychiatric inpatient hospital services and administrative day services provided in a SD/MC hospital and are reimbursed a per diem rate that includes the cost of routine hospital services and all hospital based ancillary services.

a. Acute psychiatric inpatient hospital services are those services provided by a hospital to beneficiaries for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.
b. Administrative day services are psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options and non-acute residential treatment facilities that meet the needs of the beneficiary.

D. REIMBURSEMENT METHODOLOGY AND PROCEDURES

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements.

a. Interim Rates

The State calculates an interim rate for acute psychiatric inpatient hospital services for each hospital and one statewide interim rate for administrative day services on an annual basis using the methodologies described below.

1. Administrative Day Services

The state calculates one statewide interim rate for administrative day services that is applied to all SD/MC hospitals that provide administrative day services. The statewide interim rate for administrative day services is calculated, to be effective from August 1st to July 31st of each rate year, using the following steps.

- Enter into a spreadsheet the skilled nursing facility rates calculated for each hospital that operates a distinct part nursing facility for the prospective nursing facility rate year, which runs from August 1st through July 31st.
- Identify the median rate among all hospitals that operate a distinct part nursing facility.

- The interim rate for administrative day services is equal to the median skilled nursing facility rate for hospitals that operate a distinct part nursing facility.

2. Acute Psychiatric Inpatient Hospital Services
   Each hospital's interim rate for acute psychiatric inpatient hospital services is calculated using the following steps.
   - Enter into a spreadsheet the allowable Medi-Cal acute psychiatric inpatient hospital service costs and total allowable Medi-Cal acute psychiatric inpatient days as determined and reported in the most recently filed CMS 2552 hospital cost report and supplemental schedules for each hospital.
   - Divide gross costs by total patient days to calculate a cost per day for each hospital.
   - The interim rate is equal to the lower of the cost per day multiplied by one plus the percentage increase from the midpoint (calendar year quarter 4) of the last updated rate year to the midpoint (calendar quarter 4) of the year for which the rates are being calculated from the Global Insight Inpatient Market Basket Index or the Schedule of Maximum Interim Rate (SMIR) for acute psychiatric inpatient hospital services.

b. Interim Payments
   Interim payments of FFP are based upon an approximation of the Medicaid (Medi-Cal) costs that are eligible for Federal Financial Participation (FFP) without exceeding the Schedule of Maximum Interim Rate (SMIR). Interim payments for SD/MC hospitals will be based upon interim per diem rates that are established by the State on an annual basis as described in this segment of the State plan.

c. Cost Report Submission
   Each SD/MC hospital will be required to file a CMS 2552 hospital cost report and supplemental schedules by December 31st following the close of the State Fiscal Year (i.e., June 30th).

d. Reconciliation
   No later than fifteen months after the close of the State Fiscal Year, each SD/MC hospital will be provided an opportunity to reconcile its approved Medi-Cal days and charges to the State's records. Each hospital will be given ninety days to file an amended cost report that reconciles its Medi-Cal days and charges with the State's records. This amended cost report is called the reconciled cost report.

e. Interim Settlement

No later than twenty-four months after the close of the State Fiscal Year, the State will complete the interim settlement of each SD/MC hospital's most recently amended cost report. The interim settlement will compare interim payments made to each SD/MC hospital with the amount determined in the CMS 2552 cost report and supplemental schedules. The CMS 2552 hospital cost report and supplemental schedules will limit reimbursement to the lower of the SD/MC hospital's allowable costs or usual and customary charge for the acute psychiatric inpatient hospital services provided. The CMS 2552 hospital cost report and supplemental schedules will limit reimbursement to the lower of the SD/MC hospitals allowable costs, usual and customary charge, or SMIR for administrative day services. The State will pay the SD/MC hospital additional amounts due if the total reimbursement calculated in the cost report is more than the interim payments made to the hospital. Any overpayments are recouped, and the federal share of the overpayments is returned to the federal government in accordance with 42 CFR 433.316.

f. Final Settlement Process

The State will complete the audit of the interim settled CMS 2552 hospital cost report and supplemental schedules within three years of the date the reconciled CMS 2552 hospital cost report and supplemental schedules are submitted and certified. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS 2552 hospital cost report and supplemental schedules are reasonable, allowable, and in accordance with State and Federal rules, regulations, and Medicare principles of reimbursement issued by the Centers for Medicare and Medicaid Services (CMS). The audit will also determine that the SD/MC hospital's CMS 2552 hospital cost report and supplemental schedules represent the actual cost of providing Psychiatric Inpatient Hospital Services in accordance with the Specialty Mental Health Program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Governmental Auditing Standards as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will pay the SD/MC hospital additional amounts due if the total reimbursement calculated in the cost report is more than the interim payments made to the hospital. Any overpayments are recouped, and the federal share of the overpayments is returned to the federal government in accordance with 42 CFR 433.316.

g. Cost Principles
For the purposes of paragraphs e and f, allowable costs will be determined using the CMS 2552 hospital cost report and the cost principles described in 42 CFR 413 and the Provider Reimbursement Manual, CMS Publication 15-1.

h. Apportioning Costs to Medicaid (Medi-Cal)
Total inpatient costs will be determined in the CMS 2552 hospital cost report and supplemental schedules. Total inpatient hospital costs will be apportioned to the Medi-Cal program using a cost per day for each routine hospital cost center and a cost-to-charge ratio for each ancillary and other hospital cost centers. For Los Angeles County-owned and –operated hospitals, relative value units are used instead of charges for apportionment. Intern and resident costs will be included in the total costs determined on the CMS 2552 and apportioned to the Medi-Cal program. The State does not reimburse these costs separately using a per resident amount methodology.

E. PROVIDERS OF PSYCHIATRIC INPATIENT HOSPITAL SERVICES
Short-Doyle/Medi-Cal (SD/MC) hospitals are eligible to provide services under this segment.

F. SCHEDULE OF MAXIMUM INTERIM RATES METHODOLOGY
The State Calculates the Schedule of Maximum Interim Rates on an annual basis and publishes those rates through an information notice that is posted to its website. The following describes the methodology used to calculate the statewide maximum interim rate for acute psychiatric inpatient hospital services and administrative day services provided by SD/MC hospitals.

a. Acute Psychiatric Inpatient Hospital Services
The Maximum Interim Rate for acute psychiatric inpatient hospital services was initially developed using cost reports filed for Fiscal Year 1989-90 (July 1, 1989 through June 30, 1990) using the following methodology.

1. Enter into a spreadsheet all hospitals, their reported gross costs for all patients' acute psychiatric inpatient hospital services, and all reported days for all patients' acute psychiatric inpatient hospital services.
2. Divide gross costs by total of days for all patients' acute psychiatric inpatient hospital services to calculate a cost per day for each hospital.
3. Remove from the data set those hospitals that have a cost per day that is one standard deviation above the mean.

4. After completing step 3, remove those hospitals that have a cost per day in the top ten percent of the remaining hospitals.
5. From the remaining hospitals, calculate the sum of gross costs reported for acute psychiatric inpatient hospital services.
6. From the remaining hospitals, calculate the sum of patient days reported for acute psychiatric inpatient hospital services.
7. Divide the sum of gross costs determined in step 5 by the sum of patient days determined in step 6 to calculate the statewide average cost per day.
8. The statewide average cost per day calculated in step 7 is increased on an annual basis by the increase from the midpoint (calendar year quarter 4) of the last updated rate year to the midpoint (calendar year quarter 4) of the year for which the rates are being calculated from the Global Insight Inpatient Market Basket Index.

b. Administrative Day Services

The maximum interim rate for administrative day services is equal to the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services. The rate is updated and published on an annual basis (for each rate year from August 1st to July 31st consistent with the nursing facility rate year described in Attachment 4.19-D of the state plan).

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. 0live 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 OF PSYCHIATRIC INPATIENT HOSPITAL SERVICES PROVIDED BY FEE-FOR-SERVICE/MEDI-CAL (FFS/MC) HOSPITALS

A. GENERAL APPLICABILITY

Reimbursement of FFS/MC Psychiatric Inpatient Hospital Services shall be as established below.

B. DEFINITIONS

"Acute psychiatric inpatient hospital service" means a service provided by a hospital to a Medi-Cal beneficiary for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.

"Administrative day service" means inpatient hospital services provided to a Medi-Cal beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the Medi-Cal beneficiary's stay at the hospital must be continued beyond the individuals' need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options and non-acute residential treatment facilities that meet the needs of the Medi-Cal beneficiary.

"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.

"Border community" means a community located outside, but in close proximity to, the California border. Limited to Pages 41 to 45.3, a border community is not considered to be out of state for the purpose of excluding coverage because of its proximity to California and historical usage of providers in the community by Medi-Cal beneficiaries.

"Disproportionate share hospital" means a FFS/MC hospital that serves a disproportionate share of low-income people as defined at page 18 and following of this Attachment 4.19-A.

"FFS/MC contract hospital" means a Fee-for-Service/Medi-Cal Hospital that is a disproportionate share hospital or a traditional hospital, or a hospital listed on page 45.3. FFS/MC contract hospitals contract with the negotiating entity to provide psychiatric inpatient hospital services.

"Fee-for-Service/Medi-Cal hospital" means a hospital that submits claims for reimbursement of psychiatric inpatient hospital services to the State's fiscal intermediary and include all hospitals, except for those hospitals identified as SD/MC hospitals in Attachment 4.19-A, pages 38-40.5.

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

"Negotiating Entity" means an entity which authorizes services and negotiates rates with the FFS/MC Hospitals. A negotiating entity may be a county, counties acting jointly, or another governmental entity.

"Per diem rate" means a daily rate, for each allowable psychiatric accommodation code, for reimbursable psychiatric inpatient hospital services for a beneficiary for the day of admission and each day that services are provided excluding the day of discharge.

"Psychiatric inpatient hospital professional services" means services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.

"Psychiatric inpatient hospital service" means an acute psychiatric inpatient hospital service or an administrative day service.

"Routine Hospital services" means bed, board, and all medical, nursing, and support services usually provided to an inpatient by a hospital. Routine hospital services do not include hospital-based ancillary services, psychiatrist or other physician services, or psychologist services.

"Traditional Hospital" means a FFS/MC hospital that, according to historical Medi-Cal payment data for the fiscal year that is two years prior to the fiscal year for which rates are being developed provided services to beneficiaries of the negotiating entity that account for at least five percent or twenty thousand dollars, whichever is more, of the total fiscal year Medi-Cal psychiatric inpatient hospital service payments made to FFS/MC hospitals for beneficiaries of the negotiating entity.

C. REIMBURSEMENT METHODOLOGIES AND PROCEDURES

1. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES PROVIDED BY FEE-FOR-SERVICE/MEDI-CAL CONTRACT HOSPITALS

a. Reimbursement (a per diem rate) for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal contract hospital will be based on a negotiated per diem rate negotiated between the negotiating entity and the hospital on an annual basis. The starting point for this negotiation will be the hospital's routine and ancillary costs of providing psychiatric inpatient hospital services as reported in its most recently filed CMS 2552 cost report. The negotiating entity and hospital will also consider the trend of the hospital's routine costs, the trend of the hospital's ancillary costs, and the hospital's usual and customary charge for psychiatric inpatient hospital services in negotiating the rate. The negotiated per diem rate negotiated between the negotiating entity and a hospital may be less than, equal to, or greater than the starting point and will not exceed the lower of the hospital's usual and customary charge or the maximum per diem rate for each accommodation code as calculated pursuant to the methodology described in Section C.1.d of this segment of the State plan.

When a hospital is owned or operated by the same organizational entity as the negotiating entity, the per diem rate will be submitted by the negotiating entity and is subject to approval by the State. The State will approve the per diem rate submitted by the negotiating entity if it is not greater than the lower of the following:

- Highest per diem rate within the State, negotiated by a different negotiating entity for a different hospital.
- The hospital's customary charge.
- The maximum rate calculated pursuant to C.1.d of this segment.

b. The negotiated per diem rate includes routine hospital services and all hospital-based ancillary services.

c. Only one negotiated per diem rate for each allowable psychiatric accommodation code for each negotiated rate Fee-for-Service/Medi-Cal hospital may be established. The negotiated per diem rate will not be subject to retrospective adjustment to cost.

d. The Maximum negotiated reimbursement rate for each allowable accommodation code and rate region will be determined by the State on an annual basis pursuant to the following methodology:
   i. The State will identify all Fee-for-Service/Medi-Cal Contract Hospitals in Fiscal Year 2013-14.

ii. The State will obtain the number of days and direct expenses within the psychiatric acute inpatient cost center plus costs allocated to the psychiatric acute inpatient cost center from non-revenue producing cost centers for each hospital identified in (i) above from each hospital's audited 2013-14 Hospital Annual Disclosure Report filed with the Office of Statewide Health Planning and Development. Direct expenses may include salaries and wages, employee benefits, professional fees, supplies, purchased services, depreciation expense, leases and rentals, and other direct expenses within the psychiatric acute inpatient cost center. Direct expenses do not include professional costs and ancillary costs.

iii. The State will calculate a weighted average direct expense per day using the data obtained in (ii) above. The weighted average will be equal to the total expenses within the psychiatric acute inpatient cost center summed across all hospitals identified in (i) above divided by the total patient days within the psychiatric acute inpatient cost center summed across all hospitals identified in (i) above.

iv. The State will increase the weighted average expense per day as calculated in (iii) by 16 percent to incorporate the cost of ancillary services.

v. The State will annually increase the rates calculated in (iv) by the percentage increase from the midpoint (calendar year quarter 4) of the last updated rate year to the midpoint (calendar year quarter 4) of the rate year for which the rates are being calculated from the Global Insight Inpatient Market Basket Index.

e. The per-diem rate for administrative day services will be based upon 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 16 percent of the prospective class median rate. The state will calculate one statewide rate for administrative day services that is applied to all FFS/MC contract hospitals that provide administrative day services. The statewide rate for administrative day services, to be effective from August 1st through July 31st of each rate year, will be calculated using the following steps:

- Enter into a spreadsheet the skilled nursing facility rates calculated under Attachment 4.19-D for each hospital that operates a distinct part nursing facility for the prospective nursing facility rate-year, which runs from August 1st through July 31st.

- Identify the median rate among all hospitals that operate a distinct part nursing facility.
- The rate for administrative day services is equal to the median skilled nursing facility rate for hospitals that operate a distinct part nursing facility.

f. Reimbursement for acute psychiatric inpatient hospital services provided by FFS/MC contract hospitals will be based on the negotiated per diem rate, less third party liability and patient share of cost.
g. Reimbursement for administrative day services provided by FFS/MC contract hospitals will be based on the per diem rate for administrative day services less third party liability and patient share of cost.

h. The negotiated per diem rate less third party liability and patient share of cost shall be considered to be payment in full for psychiatric inpatient hospital services provided to a beneficiary.

2. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES FOR NON-NEGOTIATED RATE, FEE-FOR-SERVICE/MEDI-CAL HOSPITALS

a. Reimbursement rates (a per diem rate) for acute psychiatric inpatient hospital services for all FFS/MC hospitals except FFS/MC contract hospitals shall be determined by the State.
   i. The per diem rate will be calculated by the State prior to the beginning of each fiscal year and will not be modified for subsequent rate changes among Fee-for-Service/Medi-Cal negotiated rate hospitals or the addition of new Fee-for-Service/Medi-Cal negotiated rate hospitals.
   ii. One per diem rate for each allowable psychiatric accommodation code per non-negotiated rate, Fee-for-Service/Medi-Cal hospital per Rate Region listed in (7) will be established and used.
   iii. The per diem rate will not be subject to retrospective adjustment to cost.

b. The per diem rate will include routine hospital services and all hospital-based ancillary services

c. The per diem rate will equal the weighted average per diem rates negotiated for all Fee-for-Service/Medi-Cal hospitals within the Rate Region where the non-negotiated rate Fee-for-Service/Medi-Cal hospital is located. The per diem rate, when there are no Fee-for-Service/Medi-Cal hospitals with a negotiated rate within the Rate Region, will equal the weighted average per diem rate negotiated for all Fee-for Service/Medi-Cal hospitals statewide. The weighted average per diem rate, whether regional or statewide, will be calculated as follows:

i. The Fee-for-Service/Medi-Cal acute psychiatric inpatient hospital services patient days by accommodation code and by Fee-for-Service/Medi-Cal contract hospital from two fiscal years prior to the fiscal year for which the rate is being computed will be multiplied by the negotiated per diem rate by accommodation code and by Fee-for-Service/Medi-Cal contract hospital for the fiscal year for which the rate is being computed.

ii. The sum of the products from (a) by accommodation code for all Fee-for-Service/Medi-Cal contract hospitals within a Rate Region (or statewide when developing a statewide weighted average) will be divided by the Fee-for-Service/Medi-Cal acute psychiatric inpatient hospital services patient days by accommodation code for FFS/MC contract hospitals within the Rate Region (or statewide) that have a negotiated rate to compute the weighted average per diem rate for each accommodation code within the Rate Region (or statewide).

Reimbursement for administrative day services will be the rate 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 costs of ancillary service equal to 16 percent of the prospective class median rate. The state will calculate one statewide rate for administrative day services that is applied to all FFS/MC hospitals that provide administrative day services. The Statewide rate for administrative day services will be calculated, to be effective from August 1st through July 31st of each rate year, using the following steps:

- Enter into a spreadsheet the skilled nursing facility rates calculated under Attachment 4. 19-D for each hospital that operates a distinct part nursing facility for the prospective nursing facility rate year, which runs August 1st through July 31st.
- Identify the median rate among all hospitals that operate a distinct part nursing facility.
- The rate for administrative day services is equal to the median skilled nursing facility rate for hospitals that operate a distinct part nursing facility.

d. For both acute psychiatric inpatient hospital services and administrative day services, reimbursement to the non-negotiated, Fee-for-Service/Medi-Cal hospital will be based on the lower of the hospitals customary charge or calculated per diem rate less third party liability and patient share of cost.

e. The Rate Regions, including specified border communities, are:

i. Superior – Butte, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama and Trinity Counties and the border communities of Ashland, Brookings, Cave Junction, Jacksonville, Grants Pass, Klamath Falls, Lakeview, Medford, and Merrill Oregon.

ii. 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, Minden, Reno, Sparks, and Zephyr Cove, Nevada.

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

iv. Southern California – Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara and Ventura Counties and the border communities of Las Vegas, and Henderson, Nevada, and Kingman, Lake Havasu City, Parker and Yuma Arizona.

v. Los Angeles County

The following is a list of FFS/MC contract hospitals that are not disproportionate share hospitals or traditional hospitals as those terms are defined in Attachment 4.19-A, pages 41-45.2.

1. Eden Medical Center
2. Aurora Las Encinas Hospital
3. BHC Alhambra Hospital
4. Citrus Valley Medical Center
5. College Hospital Cerritos
6. Community Hospital Long Beach
7. East Valley Glendora
8. Encino Hospital Medical Center
9. Glendale Adventist Medical Center
10. Grancel Village
11. Henry Mayo Newhall
12. Huntington Memorial Hospital
13. Northridge Medical Center
14. Sherman Oaks Hospital
15. Southern CA Hospital at Culver City
16. Verdugo Hills Hospital
17. Los Alamitos Medical Center
18. St. Joseph Hospital
19. Corona Regional Medical Center
20. Redlands Community Hospital
21. Alvarado Parkway Institute
22. St. Mary's Medical Center
23. Catholic Healthcare West
24. Good Samaritan Hospital
25. Aurora Vista Del Mar

State/Territory: California

REIMBURSEMENT OF INPATIENT WITHDRAWAL MANAGEMENT SERVICES

A. DEFINITIONS

"Inpatient Withdrawal Management Services" means Level 3.7 and Level 4.0 Withdrawal Management as defined in section 13.d.6 of Supplement 3 to Attachment 3.1-A of this State Plan when provided in an acute care hospital.

"Cost Report" means the CMS 2552 Hospital Cost Report.

B. REIMBURSEMENT METHODOLOGY AND PROCEDURES

A hospital shall be paid its reasonable and allowable Medicaid costs for Inpatient Withdrawal Management Services. The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursement for Inpatient Withdrawal Management Services.

1. Interim Rates
   Each county will negotiate an interim per diem rate with the hospital and submit that rate to DHCS. Each county will negotiate the interim per diem rate based upon the hospital's historical actual cost as determined in the hospital's most recently filed Cost Report. The interim rate approximates, but does not need to equal, actual cost. Interim rates shall be established on an annual basis.

2. Interim Payments
   Interim payments for Inpatient Withdrawal Management Services are based upon interim per diem rates that are negotiated by a county and a hospital on an annual basis as described in section B.1, above.

3. Cost Report Submission
   Each hospital that provides Inpatient Withdrawal Management Services that does not otherwise submit the cost report to the Department of Health Care Services annually must submit a Cost Report and supplemental schedules by November 1st following the close of the State Fiscal Year (i.e., June 30th). An extension to submit the cost report may be granted by the state for good cause.

4. Interim Settlement
   No later than eighteen months after the close of the state fiscal year, the State will complete the interim settlement of each hospital's cost report. The interim settlement will compare interim payments made to each hospital with the amount determined in the Cost Report and supplemental schedules. Final reimbursement

will be limited to the lower of the hospital's reasonable and allowable costs or usual and customary charges for inpatient withdrawal management services. The total allowable cost for providing the specific Inpatient Withdrawal Management Services is further reduced by any third party and patient payments received for the Inpatient Withdrawal Management Services. The State will pay the hospital additional amounts due if the total reimbursement calculated in the cost report is more than the interim payments made to the hospital. Any overpayments are recouped, and the federal share of the overpayments is returned to the federal government in accordance with 42 CFR 433.316.

5. Final Settlement
The State will complete the audit of the interim settled Cost Report and supplemental schedules within three years of the date the Cost Report and supplemental schedules are submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the Cost Report and supplemental schedules are reasonable, allowable, and in accordance with State and Federal rules, regulations, and Medicare principles of reimbursement issued by the Centers for Medicare and Medicaid Services (CMS). The audit will also determine that the hospital's Cost Report and supplemental schedules represent the actual cost of providing inpatient withdrawal management services in accordance with Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations, Part 200 of Title 2, Code of Federal Regulations, Generally Accepted Governmental Auditing Standards, as published by the Comptroller General of the United States and other State and Federal regulatory authorities. Final reimbursement will be limited to the lower of the hospital's reasonable and allowable costs or usual and customary charges for inpatient withdrawal management services. The total allowable cost for providing the specific Inpatient Withdrawal Management Services is further reduced by any third party and patient payments received for the Inpatient Withdrawal Management Services. The State will pay the hospital additional amounts due if the total reimbursement calculated in the cost report is more than the interim payments made to the hospital. Any overpayments are recouped, and the federal share of the overpayments is returned to the federal government in accordance with 42 CFR 433.316.

6. Cost Principles
For the purpose of paragraphs B.4 and B.5, reasonable and allowable costs will be determined using the Cost Report and the cost principles described in 42 CFR 413 and the Provider Reimbursement Manual, CMS Publications 15-1 and 15-2.

7. Apportioning Costs to Medicaid (Medi-Cal)
Total inpatient costs will be determined from the Cost Report and supplemental schedules. Total inpatient hospital costs will be apportioned to the Medi-Cal program using a cost per day for each routine hospital cost center and a cost-to-charge ratio for each ancillary and other hospital cost centers. Intern and resident costs will be included in the total costs determined on the CMS 2552 and apportioned

to the Medi-Cal program. For these Inpatient Withdrawal Management Services, the State does not reimburse these costs separately using a per resident amount methodology.

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.