CA

51551 Specific Administrative Adjustment Issues

(a)

AAs for year-to-year changes in case mix and/or outliers under the ARPD (not the PGRPD) shall be resolved in the following manner: (1) The case mix adjustment factor (CMAF) shall be calculated using the following steps: (A) The provider shall supply a listing for every Medi-Cal discharge that occurred during both the settlement fiscal period and the prior fiscal period, sorted in admission date order, and shall include as a minimum:1. The patient's last name and first initial. 2. Medi-Cal I.D. Number. 3. The admission date. 4. The discharge date. 5. The principal diagnosis code. 6. The total amount of billed charges. 7. The DRG number. 8. The DRG weight. The same set of DRG groups and weights must be used for both settlement fiscal period and prior fiscal period data. If charges for a newborn were billed together with its mother, the newborn(s) and the mother must be listed separately on this listing, each with their own DRG and weight. 9. The sum of the cost weights and the number of Medi-Cal DRG discharges on the list. The number of Medi-Cal DRG discharges on the list must equal or exceed the number of audited Medi-Cal discharges. The listing must include all Medi-Cal patients, which includes newborns that are not counted as Medi-Cal discharges. (B) The sum of the cost weights for each FPE shall be divided by their respective number of Medi-Cal discharges (not the number of patients in the listing) to obtain the average DRG weight for each fiscal period. (C) The settlement fiscal period

average DRG weight shall be divided by the prior fiscal period average DRG weight to obtain the CMAF. (D) DRG cost weights used in this Section may be any set used by Medicare during any part of either the settlement or prior fiscal period. The Department may also publish a set of Medi-Cal or California specific DRG cost weights, day outlier cutoffs and classifications as an option for the providers to use. (E) Once a case mix adjustment index is granted, each subsequent fiscal period ARPDL shall include a CMAF (even if the adjustment is negative) and the provider shall supply all required data necessary to do the CMAF calculation to the Department within 9 months after the end of each subsequent FPE. Failure to do so will result in a 20 percent reduction to the provider's current interim payments. If the data is not received within 12 months of the end of the FPE, the interim payment reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent. If a provider does not supply the data prior to the issuance of the final settlement, the CMAF shall be calculated so as to remove the affect of all previous CMAFs by compounding the previous CMAFs and applying the result to decrease the settlement fiscal periods ARPD. The provider shall not be eligible for a CMAF for any fiscal period. However, if the tentative PIRL settlement is issued within 6 months of the end of the FPE and the case mix data has not yet been supplied, then a CMAF of 1.0 shall be used for the tentative PIRL settlement only. (F) For noncontract hospitals, the DRG weights shall be modified by one of the following two methods:1. All DRG weights for all patients transferred to other acute care hospitals after being stabilized will be multiplied by 0.4 (a 60 percent reduction). 2. All DRG weights for patients transferred to other acute care hospitals after being stabilized shall be adjusted as follows:a. For each patient transferred list the charges from the hospital they were transferred to. b. Divide each patient's charges at the provider's hospital by the patient's total charges (which includes

charges from both the hospital they were transferred to and the hospital they were transferred from). c. Multiply the result of (b) for each patient by their DRG weight to obtain a new weight to use in the CMAF calculation. 3. The provider shall choose which option it will use. If the provider fails to specify an option in their AAR, the Department shall use option 1. 4. Outlier calculations for these providers shall be adjusted by using the costs and days for the patients while they are at both providers, and using the same allocation formula 1-3 above. (2) Additional reimbursement shall be granted to approximate a hospital's increases, on a per discharge basis, in the marginal cost of care beyond specified thresholds that are already reimbursed for in the ARPDL, including the CMAF. AARs for additional reimbursement due to outliers (both cost and day outliers) shall be determined as follows: (A) If the provider has received a CMAF for the settlement fiscal period, then the outlier relief shall be calculated by: 1. The hospital shall also include on the listing required under (a)(1)(A) above the following additional items: a. The length of stay for each patient. b. The outlier cutoffs, in terms of both days and costs, as determined in accordance with Medicare prospective payment rules and regulations for the applicable time period of each individual patient. However, whenever the Medicare formula uses a cost-to-charge ratio, the hospital specific cost-to-charge ratio shall be used. If the provider elects to use an alternative set of DRG weights published by the Department to calculate their CMAF, then the corresponding set of alternative outlier cutoffs must be used for each patient. c. If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for

each patient. d. For patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows: (1) The outlier cost cutoff shall be the greater of:(A) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period. (B) 1.5 multiplied by the ARPD multiplied by the DRG weight for the patient. (2) The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient. (3) The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80. e. The cost to charge ratio is determined from the cost report for both the settlement and prior fiscal period. 2. If a patient qualifies as both a day and cost outlier, they shall be treated only as a day outlier. 3. Sum the amounts calculated in (2)(A)1.c. and d. above and divide by the respective number of Medi-Cal discharges for each FPE. 4. Relief shall be calculated by subtracting the prior fiscal period result of 3. from the settlement fiscal period result of 3. 5. Once an outlier adjustment, in conjunction with a CMAF, has been granted, it shall be included in all subsequent settlements even if it is a negative adjustment. Data necessary to do the outlier calculation shall be submitted each FPE within 9 months of the end of the FPE or current interim payments shall be reduced by 20 percent. If the data is not received within 12 months of the end of the FPE, the interim payments reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent. (B) If a provider has not elected a case mix adjustment index, then relief for outliers shall be calculated as follows: 1. Providers shall provide lists containing the number of patients for every length of stay for both the settlement fiscal period and the prior fiscal period. For newborns not counted as separate Medi-Cal discharges, their days shall be added to their mother's. 2. The settlement fiscal

period and prior fiscal period mean lengths of stay for all Medi-Cal patients shall be calculated by dividing total Medi-Cal patient days (including nursery days) by Medi-Cal discharges for each respective fiscal period. 3. Calculate the standard deviation of the length of stay for all patients in the prior fiscal period. 4. Compute 1.94 standard deviations of the mean length of stay in the prior fiscal period and add the result to the mean length of stay in the prior fiscal period. 5. Round the result in 4. above down to the next whole number to establish the outlier threshold to be used for both prior and settlement fiscal periods. 6. List the patients who exceeded the result of 5. above in either the settlement or prior fiscal period. Include in the list the patient's name, admission date, discharge date, length of stay and charges. 7. Calculate the amount of day outlier payments by:a. Subtracting the result of 5. above from the length of stay of each patient whose stay exceeded the outlier threshold each FPE. b. Sum the total days calculated in a. above for each FPE. c. Divide the number from b. above by the number of Medi-Cal discharges in each respective FPE. d. Subtract the prior fiscal period result of c. above from the settlement fiscal period result of c. e. Multiply the result of d. above by the number of settlement fiscal period Medi-Cal discharges. f. Calculate a per diem rate by dividing the settlement fiscal period MIRL by the total number of patient days (including newborn days). g. Relief is calculated by multiplying the result of 7.e. above by the result of 7.f. above. 8. For patients who do not qualify as a day outlier, additional relief shall be provided as a cost outlier as follows:a. For both the prior fiscal period and settlement fiscal period, the provider shall provide a listing of the number of patients by charge category (in either $100 or $200 increments) in order to calculate the mean and standard deviation. b. Calculate the mean charge per discharge and standard deviation for both FPEs. c. Convert the means and standard deviations to costs per discharge, by using the allowable cost

to charge ratio from the cost report for each respective FPE. d. Calculate the increase in the cost per discharge by dividing the settlement fiscal period mean cost per discharge by the prior fiscal period mean cost per discharge. e. Calculate the prior fiscal period cost outlier cutoff by adding 1.94 standard deviations to the mean cost per discharge. f. The prior fiscal period charge cutoff shall be the result of step e. above divided by the prior fiscal period allowable cost to charge ratio from the cost report. g. Calculate the settlement fiscal period charge outlier cutoff by multiplying the results of d. above by the result of f. h. For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above: (1) Last name and first initial. (2) Admission date. (3) Length of stay. (4) Charges. (5) Amount of charges over the threshold. (6) Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.i. Sum the items under (6) above for both the prior and settlement fiscal periods (separately). j. Adjust prior fiscal period costs to settlement fiscal period costs by multiplying the prior fiscal period item i. above result times the result of d. above. k. Divide the results of prior fiscal period j. above and settlement fiscal period j. above by the respective number of Medi-Cal discharges each FPE. l. Subtract the prior fiscal period result of k. above from the settlement fiscal period result of k. above. m. Multiply the result of l. above (minimum of zero) by the settlement fiscal period number of Medi-Cal discharges. n. Add the result of m. above to the MIRL and divide by the settlement fiscal period net cost of covered services. o. Multiply the lesser of the result of d. above or 1.0 by the result of n. above to calculate the additional amount of relief for cost outliers who do not qualify as day outliers. This cannot exceed the amount of the MIRL liability.

(1)

The case mix adjustment factor (CMAF) shall be calculated using the following steps: (A) The provider shall supply a listing for every Medi-Cal discharge that occurred during both the settlement fiscal period and the prior fiscal period, sorted in admission date order, and shall include as a minimum:1. The patient's last name and first initial. 2. Medi-Cal I.D. Number. 3. The admission date. 4. The discharge date. 5. The principal diagnosis code. 6. The total amount of billed charges. 7. The DRG number. 8. The DRG weight. The same set of DRG groups and weights must be used for both settlement fiscal period and prior fiscal period data. If charges for a newborn were billed together with its mother, the newborn(s) and the mother must be listed separately on this listing, each with their own DRG and weight. 9. The sum of the cost weights and the number of Medi-Cal DRG discharges on the list. The number of Medi-Cal DRG discharges on the list must equal or exceed the number of audited Medi-Cal discharges. The listing must include all Medi-Cal patients, which includes newborns that are not counted as Medi-Cal discharges. (B) The sum of the cost weights for each FPE shall be divided by their respective number of Medi-Cal discharges (not the number of patients in the listing) to obtain the average DRG weight for each fiscal period. (C) The settlement fiscal period average DRG weight shall be divided by the prior fiscal period average DRG weight to obtain the CMAF. (D) DRG cost weights used in this Section may be any set used by Medicare during any part of either the settlement or prior fiscal period. The Department may also publish a set of Medi-Cal or California specific DRG cost weights, day outlier cutoffs and classifications as an option for the providers to use. (E) Once a case mix adjustment index is granted, each subsequent fiscal period ARPDL shall include a CMAF (even if the adjustment is negative) and the provider shall supply all required data necessary to do the CMAF calculation to the Department within 9 months after the end of each subsequent FPE. Failure to do so will result in a 20 percent reduction to the provider's current interim payments. If the data is not received within

12 months of the end of the FPE, the interim payment reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent. If a provider does not supply the data prior to the issuance of the final settlement, the CMAF shall be calculated so as to remove the affect of all previous CMAFs by compounding the previous CMAFs and applying the result to decrease the settlement fiscal periods ARPD. The provider shall not be eligible for a CMAF for any fiscal period. However, if the tentative PIRL settlement is issued within 6 months of the end of the FPE and the case mix data has not yet been supplied, then a CMAF of 1.0 shall be used for the tentative PIRL settlement only. (F) For noncontract hospitals, the DRG weights shall be modified by one of the following two methods:1. All DRG weights for all patients transferred to other acute care hospitals after being stabilized will be multiplied by 0.4 (a 60 percent reduction). 2. All DRG weights for patients transferred to other acute care hospitals after being stabilized shall be adjusted as follows:a. For each patient transferred list the charges from the hospital they were transferred to. b. Divide each patient's charges at the provider's hospital by the patient's total charges (which includes charges from both the hospital they were transferred to and the hospital they were transferred from). c. Multiply the result of (b) for each patient by their DRG weight to obtain a new weight to use in the CMAF calculation. 3. The provider shall choose which option it will use. If the provider fails to specify an option in their AAR, the Department shall use option 1. 4. Outlier calculations for these providers shall be adjusted by using the costs and days for the patients while they are at both providers, and using the same allocation formula 1-3 above.

(A)

The provider shall supply a listing for every Medi-Cal discharge that occurred during both the settlement fiscal period and the prior fiscal period, sorted in admission date order, and shall include as a minimum:1. The patient's last name and first initial. 2. Medi-Cal I.D. Number. 3.

The admission date. 4. The discharge date. 5. The principal diagnosis code. 6. The total amount of billed charges. 7. The DRG number. 8. The DRG weight. The same set of DRG groups and weights must be used for both settlement fiscal period and prior fiscal period data. If charges for a newborn were billed together with its mother, the newborn(s) and the mother must be listed separately on this listing, each with their own DRG and weight. 9. The sum of the cost weights and the number of Medi-Cal DRG discharges on the list. The number of Medi-Cal DRG discharges on the list must equal or exceed the number of audited Medi-Cal discharges. The listing must include all Medi-Cal patients, which includes newborns that are not counted as Medi-Cal discharges.

1.

The patient's last name and first initial.

2.

Medi-Cal I.D. Number.

3.

The admission date.

4.

The discharge date.

5.

The principal diagnosis code.

6.

The total amount of billed charges.

7.

The DRG number.

8.

The DRG weight. The same set of DRG groups and weights must be used for both settlement fiscal period and prior fiscal period data. If charges for a newborn were billed together with its mother, the

newborn(s) and the mother must be listed separately on this listing, each with their own DRG and weight.

9.

The sum of the cost weights and the number of Medi-Cal DRG discharges on the list. The number of Medi-Cal DRG discharges on the list must equal or exceed the number of audited Medi-Cal discharges. The listing must include all Medi-Cal patients, which includes newborns that are not counted as Medi-Cal discharges.

(B)

The sum of the cost weights for each FPE shall be divided by their respective number of Medi-Cal discharges (not the number of patients in the listing) to obtain the average DRG weight for each fiscal period.

(C)

The settlement fiscal period average DRG weight shall be divided by the prior fiscal period average DRG weight to obtain the CMAF.

(D)

DRG cost weights used in this Section may be any set used by Medicare during any part of either the settlement or prior fiscal period. The Department may also publish a set of Medi-Cal or California specific DRG cost weights, day outlier cutoffs and classifications as an option for the providers to use.

(E)

Once a case mix adjustment index is granted, each subsequent fiscal period ARPDL shall include a CMAF (even if the adjustment is negative) and the provider shall supply all required data necessary to do the CMAF calculation to the Department within 9 months after the end of each subsequent FPE. Failure to do so will result in a 20 percent reduction to the provider's current interim payments. If the data is not received within 12 months of the end of the FPE, the interim payment reduction shall be increased to 100 percent, resulting in an interim

payment rate of zero percent. If a provider does not supply the data prior to the issuance of the final settlement, the CMAF shall be calculated so as to remove the affect of all previous CMAFs by compounding the previous CMAFs and applying the result to decrease the settlement fiscal periods ARPD. The provider shall not be eligible for a CMAF for any fiscal period. However, if the tentative PIRL settlement is issued within 6 months of the end of the FPE and the case mix data has not yet been supplied, then a CMAF of 1.0 shall be used for the tentative PIRL settlement only.

(F)

For noncontract hospitals, the DRG weights shall be modified by one of the following two methods:1. All DRG weights for all patients transferred to other acute care hospitals after being stabilized will be multiplied by 0.4 (a 60 percent reduction). 2. All DRG weights for patients transferred to other acute care hospitals after being stabilized shall be adjusted as follows:a. For each patient transferred list the charges from the hospital they were transferred to. b. Divide each patient's charges at the provider's hospital by the patient's total charges (which includes charges from both the hospital they were transferred to and the hospital they were transferred from). c. Multiply the result of (b) for each patient by their DRG weight to obtain a new weight to use in the CMAF calculation. 3. The provider shall choose which option it will use. If the provider fails to specify an option in their AAR, the Department shall use option 1. 4. Outlier calculations for these providers shall be adjusted by using the costs and days for the patients while they are at both providers, and using the same allocation formula 1-3 above.

1.

All DRG weights for all patients transferred to other acute care hospitals after being stabilized will be multiplied by 0.4 (a 60 percent reduction).

2.

All DRG weights for patients transferred to other acute care hospitals after being stabilized shall be

adjusted as follows:a. For each patient transferred list the charges from the hospital they were transferred to. b. Divide each patient's charges at the provider's hospital by the patient's total charges (which includes charges from both the hospital they were transferred to and the hospital they were transferred from). c. Multiply the result of (b) for each patient by their DRG weight to obtain a new weight to use in the CMAF calculation.

a.

For each patient transferred list the charges from the hospital they were transferred to.

b.

Divide each patient's charges at the provider's hospital by the patient's total charges (which includes charges from both the hospital they were transferred to and the hospital they were transferred from).

c.

Multiply the result of (b) for each patient by their DRG weight to obtain a new weight to use in the CMAF calculation.

3.

The provider shall choose which option it will use. If the provider fails to specify an option in their AAR, the Department shall use option 1.

4.

Outlier calculations for these providers shall be adjusted by using the costs and days for the patients while they are at both providers, and using the same allocation formula 1-3 above.

(2)

Additional reimbursement shall be granted to approximate a hospital's increases, on a per discharge basis, in the marginal cost of care beyond specified thresholds that are already reimbursed for in the ARPDL, including the CMAF. AARs for additional reimbursement due to outliers (both cost and day outliers) shall be determined as follows: (A) If the provider has received a CMAF for the settlement fiscal period, then the outlier relief shall be calculated by: 1. The hospital shall also include on the listing

required under (a)(1)(A) above the following additional items: a. The length of stay for each patient. b. The outlier cutoffs, in terms of both days and costs, as determined in accordance with Medicare prospective payment rules and regulations for the applicable time period of each individual patient. However, whenever the Medicare formula uses a cost-to-charge ratio, the hospital specific cost-to-charge ratio shall be used. If the provider elects to use an alternative set of DRG weights published by the Department to calculate their CMAF, then the corresponding set of alternative outlier cutoffs must be used for each patient. c. If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for each patient. d. For patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows: (1) The outlier cost cutoff shall be the greater of:(A) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period. (B) 1.5 multiplied by the ARPD multiplied by the DRG weight for the patient. (2) The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient. (3) The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80. e. The cost to charge ratio is determined from the cost report for both the settlement and prior fiscal period. 2. If a patient qualifies as both a day and cost outlier, they shall be treated only as a day outlier. 3. Sum the amounts calculated in (2)(A)1.c. and d. above and divide by the respective number of Medi-Cal discharges for each FPE. 4. Relief shall be calculated by subtracting the prior fiscal period result of 3. from the settlement fiscal period result of 3. 5. Once an outlier adjustment, in

conjunction with a CMAF, has been granted, it shall be included in all subsequent settlements even if it is a negative adjustment. Data necessary to do the outlier calculation shall be submitted each FPE within 9 months of the end of the FPE or current interim payments shall be reduced by 20 percent. If the data is not received within 12 months of the end of the FPE, the interim payments reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent. (B) If a provider has not elected a case mix adjustment index, then relief for outliers shall be calculated as follows: 1. Providers shall provide lists containing the number of patients for every length of stay for both the settlement fiscal period and the prior fiscal period. For newborns not counted as separate Medi-Cal discharges, their days shall be added to their mother's. 2. The settlement fiscal period and prior fiscal period mean lengths of stay for all Medi-Cal patients shall be calculated by dividing total Medi-Cal patient days (including nursery days) by Medi-Cal discharges for each respective fiscal period. 3. Calculate the standard deviation of the length of stay for all patients in the prior fiscal period. 4. Compute 1.94 standard deviations of the mean length of stay in the prior fiscal period and add the result to the mean length of stay in the prior fiscal period. 5. Round the result in 4. above down to the next whole number to establish the outlier threshold to be used for both prior and settlement fiscal periods. 6. List the patients who exceeded the result of 5. above in either the settlement or prior fiscal period. Include in the list the patient's name, admission date, discharge date, length of stay and charges. 7. Calculate the amount of day outlier payments by:a. Subtracting the result of 5. above from the length of stay of each patient whose stay exceeded the outlier threshold each FPE. b. Sum the total days calculated in a. above for each FPE. c. Divide the number from b. above by the number of Medi-Cal discharges in each respective FPE. d. Subtract the prior fiscal period result of c. above from the settlement fiscal period result of c. e. Multiply the result of d. above by the number of settlement fiscal

period Medi-Cal discharges. f. Calculate a per diem rate by dividing the settlement fiscal period MIRL by the total number of patient days (including newborn days). g. Relief is calculated by multiplying the result of 7.e. above by the result of 7.f. above. 8. For patients who do not qualify as a day outlier, additional relief shall be provided as a cost outlier as follows:a. For both the prior fiscal period and settlement fiscal period, the provider shall provide a listing of the number of patients by charge category (in either $100 or $200 increments) in order to calculate the mean and standard deviation. b. Calculate the mean charge per discharge and standard deviation for both FPEs. c. Convert the means and standard deviations to costs per discharge, by using the allowable cost to charge ratio from the cost report for each respective FPE. d. Calculate the increase in the cost per discharge by dividing the settlement fiscal period mean cost per discharge by the prior fiscal period mean cost per discharge. e. Calculate the prior fiscal period cost outlier cutoff by adding 1.94 standard deviations to the mean cost per discharge. f. The prior fiscal period charge cutoff shall be the result of step e. above divided by the prior fiscal period allowable cost to charge ratio from the cost report. g. Calculate the settlement fiscal period charge outlier cutoff by multiplying the results of d. above by the result of f. h. For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above: (1) Last name and first initial. (2) Admission date. (3) Length of stay. (4) Charges. (5) Amount of charges over the threshold. (6) Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.i. Sum the items under (6) above for both the prior and settlement fiscal periods (separately). j. Adjust prior fiscal period costs to settlement fiscal period costs by multiplying the prior fiscal period item i. above result times the result of d. above. k. Divide the results of prior fiscal period j. above and settlement fiscal period j. above by the respective number of Medi-Cal discharges each

FPE. l. Subtract the prior fiscal period result of k. above from the settlement fiscal period result of k. above. m. Multiply the result of l. above (minimum of zero) by the settlement fiscal period number of Medi-Cal discharges. n. Add the result of m. above to the MIRL and divide by the settlement fiscal period net cost of covered services. o. Multiply the lesser of the result of d. above or 1.0 by the result of n. above to calculate the additional amount of relief for cost outliers who do not qualify as day outliers. This cannot exceed the amount of the MIRL liability.

(A)

If the provider has received a CMAF for the settlement fiscal period, then the outlier relief shall be calculated by: 1. The hospital shall also include on the listing required under (a)(1)(A) above the following additional items: a. The length of stay for each patient. b. The outlier cutoffs, in terms of both days and costs, as determined in accordance with Medicare prospective payment rules and regulations for the applicable time period of each individual patient. However, whenever the Medicare formula uses a cost-to-charge ratio, the hospital specific cost-to-charge ratio shall be used. If the provider elects to use an alternative set of DRG weights published by the Department to calculate their CMAF, then the corresponding set of alternative outlier cutoffs must be used for each patient. c. If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for each patient. d. For patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows: (1) The outlier cost cutoff shall be the greater of:(A) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period. (B) 1.5 multiplied by the ARPD multiplied by the DRG weight for

the patient. (2) The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient. (3) The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80. e. The cost to charge ratio is determined from the cost report for both the settlement and prior fiscal period. 2. If a patient qualifies as both a day and cost outlier, they shall be treated only as a day outlier. 3. Sum the amounts calculated in (2)(A)1.c. and d. above and divide by the respective number of Medi-Cal discharges for each FPE. 4. Relief shall be calculated by subtracting the prior fiscal period result of 3. from the settlement fiscal period result of 3. 5. Once an outlier adjustment, in conjunction with a CMAF, has been granted, it shall be included in all subsequent settlements even if it is a negative adjustment. Data necessary to do the outlier calculation shall be submitted each FPE within 9 months of the end of the FPE or current interim payments shall be reduced by 20 percent. If the data is not received within 12 months of the end of the FPE, the interim payments reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent.

1.

The hospital shall also include on the listing required under (a)(1)(A) above the following additional items: a. The length of stay for each patient. b. The outlier cutoffs, in terms of both days and costs, as determined in accordance with Medicare prospective payment rules and regulations for the applicable time period of each individual patient. However, whenever the Medicare formula uses a cost-to-charge ratio, the hospital specific cost-to-charge ratio shall be used. If the provider elects to use an alternative set of DRG weights published by the Department to calculate their CMAF, then the corresponding set of alternative outlier cutoffs must be used for each patient. c. If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for each patient. d. For

patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows: (1) The outlier cost cutoff shall be the greater of:(A) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period. (B) 1.5 multiplied by the ARPD multiplied by the DRG weight for the patient. (2) The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient. (3) The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80. e. The cost to charge ratio is determined from the cost report for both the settlement and prior fiscal period.

a.

The length of stay for each patient.

b.

The outlier cutoffs, in terms of both days and costs, as determined in accordance with Medicare prospective payment rules and regulations for the applicable time period of each individual patient. However, whenever the Medicare formula uses a cost-to-charge ratio, the hospital specific cost-to-charge ratio shall be used. If the provider elects to use an alternative set of DRG weights published by the Department to calculate their CMAF, then the corresponding set of alternative outlier cutoffs must be used for each patient.

c.

If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for each patient.

d.

For patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows: (1) The outlier cost cutoff shall be the greater of:(A) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the

appropriate service period. (B) 1.5 multiplied by the ARPD multiplied by the DRG weight for the patient. (2) The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient. (3) The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80.

(1)

The outlier cost cutoff shall be the greater of:(A) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period. (B) 1.5 multiplied by the ARPD multiplied by the DRG weight for the patient.

(A)

A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period.

(B)

1.5 multiplied by the ARPD multiplied by the DRG weight for the patient.

(2)

The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient.

(3)

The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80.

e.

The cost to charge ratio is determined from the cost report for both the settlement and prior fiscal period.

2.

If a patient qualifies as both a day and cost outlier, they shall be treated only as a day outlier.

3.

Sum the amounts calculated in (2)(A)1.c. and d. above and divide by the respective number of Medi-Cal discharges for each FPE.

4.

Relief shall be calculated by subtracting the prior fiscal period result of 3. from the settlement fiscal

period result of 3.

5.

Once an outlier adjustment, in conjunction with a CMAF, has been granted, it shall be included in all subsequent settlements even if it is a negative adjustment. Data necessary to do the outlier calculation shall be submitted each FPE within 9 months of the end of the FPE or current interim payments shall be reduced by 20 percent. If the data is not received within 12 months of the end of the FPE, the interim payments reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent.

(B)

If a provider has not elected a case mix adjustment index, then relief for outliers shall be calculated as follows: 1. Providers shall provide lists containing the number of patients for every length of stay for both the settlement fiscal period and the prior fiscal period. For newborns not counted as separate Medi-Cal discharges, their days shall be added to their mother's. 2. The settlement fiscal period and prior fiscal period mean lengths of stay for all Medi-Cal patients shall be calculated by dividing total Medi-Cal patient days (including nursery days) by Medi-Cal discharges for each respective fiscal period. 3. Calculate the standard deviation of the length of stay for all patients in the prior fiscal period. 4. Compute 1.94 standard deviations of the mean length of stay in the prior fiscal period and add the result to the mean length of stay in the prior fiscal period. 5. Round the result in 4. above down to the next whole number to establish the outlier threshold to be used for both prior and settlement fiscal periods. 6. List the patients who exceeded the result of 5. above in either the settlement or prior fiscal period. Include in the list the patient's name, admission date, discharge date, length of stay and charges. 7. Calculate the amount of day outlier payments by:a. Subtracting the result of 5. above from the length of stay of each patient whose stay exceeded the outlier threshold each FPE. b. Sum the total days calculated in a. above for each FPE. c. Divide the number from b. above by the number of Medi-Cal discharges in each respective FPE. d.

Subtract the prior fiscal period result of c. above from the settlement fiscal period result of c. e. Multiply the result of d. above by the number of settlement fiscal period Medi-Cal discharges. f. Calculate a per diem rate by dividing the settlement fiscal period MIRL by the total number of patient days (including newborn days). g. Relief is calculated by multiplying the result of 7.e. above by the result of 7.f. above. 8. For patients who do not qualify as a day outlier, additional relief shall be provided as a cost outlier as follows:a. For both the prior fiscal period and settlement fiscal period, the provider shall provide a listing of the number of patients by charge category (in either $100 or $200 increments) in order to calculate the mean and standard deviation. b. Calculate the mean charge per discharge and standard deviation for both FPEs. c. Convert the means and standard deviations to costs per discharge, by using the allowable cost to charge ratio from the cost report for each respective FPE. d. Calculate the increase in the cost per discharge by dividing the settlement fiscal period mean cost per discharge by the prior fiscal period mean cost per discharge. e. Calculate the prior fiscal period cost outlier cutoff by adding 1.94 standard deviations to the mean cost per discharge. f. The prior fiscal period charge cutoff shall be the result of step e. above divided by the prior fiscal period allowable cost to charge ratio from the cost report. g. Calculate the settlement fiscal period charge outlier cutoff by multiplying the results of d. above by the result of f. h. For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above: (1) Last name and first initial. (2) Admission date. (3) Length of stay. (4) Charges. (5) Amount of charges over the threshold. (6) Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.i. Sum the items under (6) above for both the prior and settlement fiscal periods (separately). j. Adjust prior fiscal period costs to settlement fiscal period costs by multiplying the prior fiscal period item i. above result times the result of d. above. k. Divide the results of prior fiscal period j. above and settlement fiscal period j. above by the respective number of Medi-Cal discharges

each FPE. l. Subtract the prior fiscal period result of k. above from the settlement fiscal period result of k. above. m. Multiply the result of l. above (minimum of zero) by the settlement fiscal period number of Medi-Cal discharges. n. Add the result of m. above to the MIRL and divide by the settlement fiscal period net cost of covered services. o. Multiply the lesser of the result of d. above or 1.0 by the result of n. above to calculate the additional amount of relief for cost outliers who do not qualify as day outliers. This cannot exceed the amount of the MIRL liability.

1.

Providers shall provide lists containing the number of patients for every length of stay for both the settlement fiscal period and the prior fiscal period. For newborns not counted as separate Medi-Cal discharges, their days shall be added to their mother's.

2.

The settlement fiscal period and prior fiscal period mean lengths of stay for all Medi-Cal patients shall be calculated by dividing total Medi-Cal patient days (including nursery days) by Medi-Cal discharges for each respective fiscal period.

3.

Calculate the standard deviation of the length of stay for all patients in the prior fiscal period.

4.

Compute 1.94 standard deviations of the mean length of stay in the prior fiscal period and add the result to the mean length of stay in the prior fiscal period.

5.

Round the result in 4. above down to the next whole number to establish the outlier threshold to be used for both prior and settlement fiscal periods.

6.

List the patients who exceeded the result of 5. above in either the settlement or prior fiscal period. Include in the list the patient's name, admission date, discharge date, length of stay and charges.

7.

Calculate the amount of day outlier payments by:a. Subtracting the result of 5. above from the length of stay of each patient whose stay exceeded the outlier threshold each FPE. b. Sum the total days calculated in a. above for each FPE. c. Divide the number from b. above by the number of Medi-Cal discharges in each respective FPE. d. Subtract the prior fiscal period result of c. above from the settlement fiscal period result of c. e. Multiply the result of d. above by the number of settlement fiscal period Medi-Cal discharges. f. Calculate a per diem rate by dividing the settlement fiscal period MIRL by the total number of patient days (including newborn days). g. Relief is calculated by multiplying the result of 7.e. above by the result of 7.f. above.

a.

Subtracting the result of 5. above from the length of stay of each patient whose stay exceeded the outlier threshold each FPE.

b.

Sum the total days calculated in a. above for each FPE.

c.

Divide the number from b. above by the number of Medi-Cal discharges in each respective FPE.

d.

Subtract the prior fiscal period result of c. above from the settlement fiscal period result of c.

e.

Multiply the result of d. above by the number of settlement fiscal period Medi-Cal discharges.

f.

Calculate a per diem rate by dividing the settlement fiscal period MIRL by the total number of patient days (including newborn days).

g.

Relief is calculated by multiplying the result of 7.e. above by the result of 7.f. above.

8.

For patients who do not qualify as a day outlier, additional relief shall be provided as a cost outlier as follows:a. For both the prior fiscal period and settlement fiscal period, the provider shall provide a listing of the number of patients by charge category (in either $100 or $200 increments) in order to calculate the mean and standard deviation. b. Calculate the mean charge per discharge and standard deviation for both FPEs. c. Convert the means and standard deviations to costs per discharge, by using the allowable cost to charge ratio from the cost report for each respective FPE. d. Calculate the increase in the cost per discharge by dividing the settlement fiscal period mean cost per discharge by the prior fiscal period mean cost per discharge. e. Calculate the prior fiscal period cost outlier cutoff by adding 1.94 standard deviations to the mean cost per discharge. f. The prior fiscal period charge cutoff shall be the result of step e. above divided by the prior fiscal period allowable cost to charge ratio from the cost report. g. Calculate the settlement fiscal period charge outlier cutoff by multiplying the results of d. above by the result of f. h. For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above: (1) Last name and first initial. (2) Admission date. (3) Length of stay. (4) Charges. (5) Amount of charges over the threshold. (6) Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.i. Sum the items under (6) above for both the prior and settlement fiscal periods (separately). j. Adjust prior fiscal period costs to settlement fiscal period costs by multiplying the prior fiscal period item i. above result times the result of d. above. k. Divide the results of prior fiscal period j. above and settlement fiscal period j. above by the respective number of Medi-Cal discharges each FPE. l. Subtract the prior fiscal period result of k. above from the settlement fiscal period result of k. above. m. Multiply the result of l. above (minimum of zero) by the settlement fiscal period number of Medi-Cal discharges. n. Add the result of m. above to the MIRL and divide by the settlement fiscal period net cost of covered services. o. Multiply the lesser of the result of d. above or 1.0 by the result of n. above to calculate the additional amount of relief for cost outliers who do not qualify as day outliers. This cannot exceed the amount of the MIRL liability.

a.

For both the prior fiscal period and settlement fiscal period, the provider shall provide a listing of the number of patients by charge category (in either $100 or $200 increments) in order to calculate the mean and standard deviation.

b.

Calculate the mean charge per discharge and standard deviation for both FPEs.

c.

Convert the means and standard deviations to costs per discharge, by using the allowable cost to charge ratio from the cost report for each respective FPE.

d.

Calculate the increase in the cost per discharge by dividing the settlement fiscal period mean cost per discharge by the prior fiscal period mean cost per discharge.

e.

Calculate the prior fiscal period cost outlier cutoff by adding 1.94 standard deviations to the mean cost per discharge.

f.

The prior fiscal period charge cutoff shall be the result of step e. above divided by the prior fiscal period allowable cost to charge ratio from the cost report.

g.

Calculate the settlement fiscal period charge outlier cutoff by multiplying the results of d. above by the result of f.

h.

For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above: (1) Last name and first initial. (2) Admission date. (3) Length of stay. (4) Charges. (5) Amount of charges over the threshold. (6) Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.

(1)

Last name and first initial.

(2)

Admission date.

(3)

Length of stay.

(4)

Charges.

(5)

Amount of charges over the threshold.

(6)

Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.

i.

Sum the items under (6) above for both the prior and settlement fiscal periods (separately).

j.

Adjust prior fiscal period costs to settlement fiscal period costs by multiplying the prior fiscal period item i. above result times the result of d. above.

k.

Divide the results of prior fiscal period j. above and settlement fiscal period j. above by the respective number of Medi-Cal discharges each FPE.

l.

Subtract the prior fiscal period result of k. above from the settlement fiscal period result of k. above.

m.

Multiply the result of l. above (minimum of zero) by the settlement fiscal period number of Medi-Cal discharges.

n.

Add the result of m. above to the MIRL and divide by the settlement fiscal period net cost of covered services.

o.

Multiply the lesser of the result of d. above or 1.0 by the result of n. above to calculate the additional amount of relief for cost outliers who do not qualify as day outliers. This cannot exceed the amount of the MIRL liability.

(b)

AAs for changes in labor costs shall be resolved in the following manner:(1) Relief from the SWI and EBI can be granted if, and only if, the basis is due to labor/benefit cost increases per discharge resulting from either the new adherence to existing requirements imposed by government regulations, rules, and/or statutes or the adherence to new requirements imposed by government regulations, rules, and/or statues. This includes new rules and new adherence to rules imposed by the Joint Commission on Accreditation of Health Organizations. The adherence to the regulations, rules, and/or statutes must be necessary to legally render the provided services to Medi-Cal recipients. (2) The Department will be authorized to grant relief if the provider meets the criteria for relief. Any relief granted shall be based upon an analysis of labor costs both prior and subsequent to the effective date of adherence to the requirements. Any request for relief will require the following: (A) A summation of the governmental requirements necessitating the increase in labor costs; (B) Additional hours and staff required to adhere to the governmental requirements. The request will specify: 1. The exact title(s) of the added staff; 2. The appropriate employee cost category; and 3. The number of hours and hourly rates for each added or deleted staff member. (C) Source of the additional support, e.g., new hire or transferred from another employee classification; and (D) The appropriate pages of the Medi-Cal cost report

reflecting the additional costs associated with the increased hours. (3) A separate request shall be rendered for each affected cost center. The cost centers for appeal purposes shall be the exact same cost centers as disclosed in the provider's Medi-Cal cost report as audited by the Department. Relief may be granted only for those cost centers that incurred the expenses as the result of governmental requirements. (4) The Department shall evaluate the submitted data to determine any changes in the following areas for each affected cost center: (A) Labor hours per discharge; (B) Labor costs per discharge; (C) Changes made in other employee classifications that resulted in labor cost increases or decreases. (5) The unit measure of change shall be the ARPD. Any relief granted shall be on a per discharge basis by adjusting the ARPD to incorporate the increased, if any, labor costs per discharge which were not reimbursed in the ARPD and which do not overlap with any other issues. Any adjustments necessitated by the application of relief shall impact the base rate per discharge and will be carried forward into future settlements. (6) The only basis for relief under Subsection (b) of 51551 shall be: (A) Increased employee hours per discharge; or (B) The requirement to employ more expensive labor, e.g., replace Aides with Registered Nurses. (7) Requests for relief on the basis of increased patient acuity will be deferred to Section 51551(a). Patient acuity or service intensity shall not be entertained under Section 51551(b). (8) Relief sought on the basis of labor disputes shall not be granted. Labor disputes are inclusive of, but not limited to, strikes, arbitration, and/or labor issues where employees in an organized, collective, or unified movement refrained from physically reporting to perform their routine duties or physically reported but refrained from performing their routine duties. (9) Relief shall not be granted under 51551(b) as the result of circumstances created when the provider switched to or from nursing services instead of salaried personnel.

(1)

Relief from the SWI and EBI can be granted if, and only if, the basis is due to labor/benefit cost increases per discharge resulting from either the new adherence to existing requirements imposed by government regulations, rules, and/or statutes or the adherence to new requirements imposed by government regulations, rules, and/or statues. This includes new rules and new adherence to rules imposed by the Joint Commission on Accreditation of Health Organizations. The adherence to the regulations, rules, and/or statutes must be necessary to legally render the provided services to Medi-Cal recipients.

(2)

The Department will be authorized to grant relief if the provider meets the criteria for relief. Any relief granted shall be based upon an analysis of labor costs both prior and subsequent to the effective date of adherence to the requirements. Any request for relief will require the following: (A) A summation of the governmental requirements necessitating the increase in labor costs; (B) Additional hours and staff required to adhere to the governmental requirements. The request will specify: 1. The exact title(s) of the added staff; 2. The appropriate employee cost category; and 3. The number of hours and hourly rates for each added or deleted staff member. (C) Source of the additional support, e.g., new hire or transferred from another employee classification; and (D) The appropriate pages of the Medi-Cal cost report reflecting the additional costs associated with the increased hours.

(A)

A summation of the governmental requirements necessitating the increase in labor costs;

(B)

Additional hours and staff required to adhere to the governmental requirements. The request will specify: 1. The exact title(s) of the added staff; 2. The appropriate employee cost

category; and 3. The number of hours and hourly rates for each added or deleted staff member.

1.

The exact title(s) of the added staff;

2.

The appropriate employee cost category; and

3.

The number of hours and hourly rates for each added or deleted staff member.

(C)

Source of the additional support, e.g., new hire or transferred from another employee classification; and

(D)

The appropriate pages of the Medi-Cal cost report reflecting the additional costs associated with the increased hours.

(3)

A separate request shall be rendered for each affected cost center. The cost centers for appeal purposes shall be the exact same cost centers as disclosed in the provider's Medi-Cal cost report as audited by the Department. Relief may be granted only for those cost centers that incurred the expenses as the result of governmental requirements.

(4)

The Department shall evaluate the submitted data to determine any changes in the following areas for each affected cost center: (A) Labor hours per discharge; (B) Labor costs per discharge; (C) Changes made in other employee classifications that resulted in labor cost increases or decreases.

(A)

Labor hours per discharge;

(B)

Labor costs per discharge;

(C)

Changes made in other employee classifications that resulted in labor cost increases or decreases.

(5)

The unit measure of change shall be the ARPD. Any relief granted shall be on a per discharge basis by adjusting the ARPD to incorporate the increased, if any, labor costs per discharge which were not reimbursed in the ARPD and which do not overlap with any other issues. Any adjustments necessitated by the application of relief shall impact the base rate per discharge and will be carried forward into future settlements.

(6)

The only basis for relief under Subsection (b) of 51551 shall be: (A) Increased employee hours per discharge; or (B) The requirement to employ more expensive labor, e.g., replace Aides with Registered Nurses.

(A)

Increased employee hours per discharge; or

(B)

The requirement to employ more expensive labor, e.g., replace Aides with Registered Nurses.

(7)

Requests for relief on the basis of increased patient acuity will be deferred to Section 51551(a). Patient acuity or service intensity shall not be entertained under Section 51551(b).

(8)

Relief sought on the basis of labor disputes shall not be granted. Labor disputes are

inclusive of, but not limited to, strikes, arbitration, and/or labor issues where employees in an organized, collective, or unified movement refrained from physically reporting to perform their routine duties or physically reported but refrained from performing their routine duties.

(9)

Relief shall not be granted under 51551(b) as the result of circumstances created when the provider switched to or from nursing services instead of salaried personnel.

(c)

The following steps will be used for calculating relief for any ARPDL issues not otherwise specified in this regulation:(1) The provider shall clearly identify the issue and estimated dollar amount of relief. (2) The provider shall determine what is the specific underlying cause of the increased costs. If the underlying cause of the increased costs is not clearly stated, the AAR shall not be accepted by the Department. (3) The provider shall calculate what reimbursement, if any, is already included in the ARPDL due to this issue (such as pass-throughs or case mix covering a new service) and shall also calculate any overlap between this and other AA issues. (4) The Department shall review and correct if necessary, the provider's calculations in steps 1 through 3 above. (5) The Department shall subtract any overlap with other issues from the amount determined in steps 1 through 3 above. (6) The Department shall determine if relief is "one-time" or "formula."

(1)

The provider shall clearly identify the issue and estimated dollar amount of relief.

(2)

The provider shall determine what is the specific underlying cause of the increased costs. If the underlying cause of the increased costs is not clearly stated, the AAR shall

not be accepted by the Department.

(3)

The provider shall calculate what reimbursement, if any, is already included in the ARPDL due to this issue (such as pass-throughs or case mix covering a new service) and shall also calculate any overlap between this and other AA issues.

(4)

The Department shall review and correct if necessary, the provider's calculations in steps 1 through 3 above.

(5)

The Department shall subtract any overlap with other issues from the amount determined in steps 1 through 3 above.

(6)

The Department shall determine if relief is "one-time" or "formula."