STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

NOTICE OF PROPOSED RULEMAKING

Subject Matter of Regulations: Workers' Compensation – Official Medical Fee Schedule

TITLE 8, CALIFORNIA CODE OF REGULATIONS

NOTICE IS HEREBY GIVEN that the Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, 5307.1 and 5307.3 proposes to revise Division 1, Chapter 4.5, Subchapter 1, of title 8, California Code of Regulations sections 9789.10, 9789.11, 9789.20 - 9789.23, 9789.25, 9789.50, 9789.60, 9789.70, 9789.110 and 9789.111 in Article 5.3 relating to the Official Medical Fee Schedule, and revise section 9790 in Article 5.5 relating to the application of the Official Medical Fee Schedule (Treatment).

PROPOSED REGULATORY ACTION

The Acting Administrative Director proposes to amend Article 5.3 of Division 1, Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, by amending the following sections:

1. **Section 9789.10 Physician Services Definitions**
2. **Section 9789.11 Physician Services Rendered on or After July 1, 2004**
3. **Section 9789.20 Inpatient Hospital Fee Schedule: General Information for Inpatient Hospital Fee Schedule – Discharge On or After July 1, 2004**
4. **Section 9789.21 Definitions for Inpatient Hospital Fee Schedule**
5. **Section 9789.22 Payment of Inpatient Hospital Services**
6. **Section 9789.23 Hospital Cost to Charge Ratios, Hospital Specific Outliers, and Hospital Composite Factors**
7. **Section 9789.25 Federal Regulations, Federal Register Notices, and Payment Impact File by Date of Discharge**
8. **Section 9789.50 Pathology and Laboratory**
9. **Section 9789.60 Durable Medical Equipment, Prosthetics, Orthotics, Supplies**
10. **Section 9789.70 Ambulance Services**
11. **Section 9789.110 Update of Rules to Reflect Changes in the Medicare Payment System**
12. **Section 9789.111. Effective Date of Fee Schedule Provisions**

The Acting Administrative Director proposes to amend Article 5.5 of Division 1, Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, by amending the following section:

1. **Section 9790 Authority**

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Official Medical Fee Schedule "establish(es) or fix(es) rates, prices, or tariffs" within the meaning of Government Code section 11340.9(g) and is therefore not subject to Chapter 3.5 of the Administrative Procedure Act (commencing at Government Code section 11340) relating to administrative regulations and rulemaking.

This rulemaking proceeding to amend the Official Medical Fee Schedule is being conducted under the Administrative Director's rulemaking power under Labor Code sections 133, 4603.5, 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code sections 5307.1 and 5307.4.

This Notice and the accompanying Initial Statement of Reasons are being prepared to comply with the procedural requirements of Labor Code section 5307.4 and for the convenience of the regulated public to assist the regulated public in analyzing and commenting on this non-APA rulemaking proceeding.

PUBLIC HEARING

A public hearing has been scheduled to permit all interested persons the opportunity to present statements or arguments, either orally or in writing, with respect to the subjects noted above. The hearing will be held at the following time and place:

Date: **Friday, November 14, 2014**
Time: **10:00 a.m. to 5:00 p.m. or conclusion of business**
Place: **Elihu M. Harris State Building, Auditorium**
1515 Clay Street,
Oakland, CA 94612

In order to ensure unimpeded access for disabled individuals wishing to present comments and facilitate the accurate transcription of public comments, camera usage will be allowed in only one area of the hearing room. To provide everyone a chance to speak, public testimony will be limited to 10 minutes per speaker and should be specific to the proposed regulations. Testimony which would exceed 10 minutes may be submitted in writing.

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation or 5:00 p.m., whichever is earlier. If public comment concludes before the noon recess, no afternoon session will be held.

The Acting Administrative Director requests, but does not require that, any persons who make oral comments at the hearings also provide a written copy of their comments. Equal weight will be accorded to oral comments and written materials.

ACCESSIBILITY

State Office Buildings and Auditoriums are accessible to persons with mobility impairments. Alternate formats, assistive listening systems, sign language interpreters, or other type of reasonable

accommodation to facilitate effective communication for persons with disabilities, are available upon request. Please contact the Statewide Disability Accommodation Coordinator, Kathleen Estrada, at 1-866-681-1459 (toll free), or through the California Relay Service by dialing 711 or 1-800-735-2929 (TTY/English) or 1-800-855-3000 (TTY/Spanish) as soon as possible to request assistance.

WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action. The written comment period closes at **5:00 p.m., on Friday, November 14, 2014.** The Acting Administrative Director will consider only comments received by that time. Equal weight will be accorded to oral comments presented at the hearing and written materials.

Submit written comments concerning the proposed regulations prior to the close of the public comment period to:

Maureen Gray
Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation, Legal Unit
Post Office Box 420603
San Francisco, CA 94142

Written comments may be submitted by facsimile transmission (FAX), addressed to the above-named contact person at (510) 286-0687. Written comments may also be sent electronically (via e-mail) using the following e-mail address: dwcrules@dir.ca.gov. Unless submitted prior to or at the public hearing, all written comments must be received by no later than **5:00 p.m. on Friday, November 14, 2014**.

AUTHORITY AND REFERENCE

The Acting Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.4, 4603.5, 5307.1, and 5307.3.

Reference is to Labor Code sections 4600, 4603.2, 5307.1 and 5307.11.

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Labor Code section 4600 requires an employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

Prior to the 2003 amendment of Labor Code Section 5307.1[1], and subsequent adoption by the Administrative Director of Medicare-based fee schedules in Article 5.3 (effective January 2, 2004), the manner by which health care providers were compensated for medical services rendered in cases within the jurisdiction of the California workers' compensation system was determined according to sections 9790, et al. in Article 5.5 (Application of the Official Medical Fee Schedule).

Prior to the passage of Senate Bill 863, Labor Code Section 5307.1 provided that, except for physician services, all fees in the adopted schedule must be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems. The Administrative Director, however, may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the Medicare Payment System (Lab. Code, §5307.1(b).

With the passage of Senate Bill 863, Labor Code Section 5307.1(a)(2)(A), requires the Administrative Director to adopt a fee schedule based on the resource-based relative value scale (RBRVS) for physician services, provided the maximum reasonable fees paid shall not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services, with a four-year transition. The Acting Administrative Director has subsequently adopted a RBRVS-based physician fee schedule, effective for services rendered on or after January 1, 2014.[2]

Labor Code section 5307.1 further provides that the Administrative Director shall adjust the OMFS provisions to conform to any relevant changes in the Medicare payment system by issuing an order, exempt from Labor Code sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.2 (commencing with section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. (Lab. Code, § 5307.1(g)(2).)

The Acting Administrative Director now proposes to amend Article 5.3, sections 9789.10 - 9789.11 (physician services), 9789.20 - 9789.23, 9789.25 (inpatient hospital), 9789.50 (pathology and laboratory), 9789.60 (durable medical Equipment, prosthetics, orthotics, supplies), 9789.70 (ambulance services), 9789.110 (update of rules to reflect changes in the Medicare payment system, and 9789.111 (effective date of fee schedule provisions); and Article 5.5, section 9790 (authority).

The proposed amendments are as follows:

- Amend the fee schedules provisions in Article 5.3 and section 9790 in Article 5.5, to reiterate the applicable dates of fee schedule provisions, despite the fact the proposed amendments are declaratory of existing laws. This is because the Acting Administrative Director has become aware of the misapplication of the effective dates of various fee schedule provisions.
- Amend the inpatient hospital fee schedule provisions that address the operating disproportionate share hospital (DSH) adjustments. The proposed amendments are necessary as a result of changes made by Medicare to their operating DSH adjustment methodology.

[1] Senate Bill 228 of 2003 (Chapter 639, Statutes of 2003)
[2] Title 8, California Code of Regulations title 8 sections 9789.12.1 et seq.

- Amend the inpatient hospital fee schedule provisions that address the outlier payments for eligible transfer cases. The Acting Administrative Director has become aware of the need to clarify that hospitals transferring an inpatient to another hospital or post-acute care provider are eligible to receive an outlier payment for qualifying cases. The proposed amendments provide the methodology for determining whether a case is eligible for an outlier payment, and if so, how the payment amount would be calculated. The proposed methodology conforms to Medicare's payment methodology.
- Make minor amendments that are required to conform to the proposed changes, to update or clarify various sections of the Official Medical Fee Schedule.

The proposed regulations implement, interpret, and make specific sections 4600 and 5307.1 of the Labor Code as follows:

1. Section 9789.10 – Physician Services - Definitions

The title to section 9789.10 is amended to include the applicable dates of this section. This section is applicable to physician services rendered on or after July 1, 2004, but before January 1, 2014.

2. Section 9789.11 – Physician Services Rendered on or After July 1, 2004

The title to section 9789.11 and subdivisions (a), (b), (d), and (f) are amended to clarify the applicable dates of this section. This section is applicable to physician services rendered on or after July 1, 2004, but before January 1, 2014.

3. Section 9789.20 – General Information for Inpatient Hospital Fee Schedule – Discharge on or After July 1, 2004

Subdivision (b) is amended to update this subdivision to reflect the adoption of Resource Based Relative Value Scale (RBRVS) physician fee schedule (sections 9789.12.1 through 9789.19) effective for physician services rendered on or after January 1, 2014, and to include effective dates for the other physician fee schedule provisions applicable to services rendered before January 1, 2014.

Subdivisions (d) and (e) are amended to update the Division of Workers' Compensation webpage address.

4. Section 9789.21 – Definitions for Inpatient Hospital Fee Schedule

Subdivision (b) is amended to correct a clerical error regarding the effective date of discharge pertaining to the formula used in determining the "Capital outlier factor".

Subdivision (e)(1)(A) is amended to correct a clerical error regarding the effective date of discharge pertaining to the formula used to derive the hospital-adjusted rate for prospective capital costs.

Subdivision (e)(2)(E) is amended to adjust the operating disproportionate share adjustment (DSH) factor as a result of changes made by Medicare to the operating DSH adjustment methodology. For discharges on or after the effective date of the proposed amendment [30 days after the amendments are

filed with the Secretary of State. Date to be inserted by OAL], the operating OMFS DSH adjustment factor would be determined by the following formula: OMFS operating DSH adjustment factor equals the sum of a) the Medicare DSH operating adjustment and b) 3 * the Medicare DSH operating adjustment * the Uncompensated Care adjustment).

The "Uncompensated Care adjustment factor" is added to this subdivision to mean the change in percentage of uninsured individuals and additional Medicare adjustments, as defined in Section 1886(r) of the Social Security Act, as implemented in Title 42, Code of Regulations, Section 412.106, and as published by CMS in the Federal Register.

Subdivision (f) is amended to clarify that "costs" means the total billed charges for an admission, excluding non-medical charges such as television and telephone charges, charges for Durable Medical Equipment for in home use, charges for implantable medical devices, hardware, and/or instrumentation reimbursed under subdivision (g) of Section 9789.22, multiplied by the hospital's total cost-to-charge ratio, plus the hospital's documented paid spinal device costs, plus an additional 10% of the hospital's documented paid cost, net of discounts and rebates, not to exceed a maximum of $250.00, plus any sales tax and/or shipping and handling charges actually paid.

Subdivision (v) is added to move the definition of "spinal device" from section 9789.22(g) to this section (Definitions of Inpatient Hospital Fee Schedule).

Subdivision (w formerly v) is re-lettered.

5. Section 9789.22. Payment of Inpatient Hospital Services

Subdivision (d) is amended to: 1) update this subdivision to make reference to section 9789.111(a) which sets forth effective dates for physician fee schedule provisions including the adoption of Resource Based Relative Value Scale (RBRVS) physician fee schedule (sections 9789.12.1 through 9789.19) effective for physician services rendered on or after January 1, 2014; and 2) to substitutes "spinal device" for "spinal hardware" to conform to section 9789.21(v).

Subdivision (f)(1)(A) is amended to: 1) renumber and clarify that unless otherwise provided, this subdivision is applicable to inpatient services for cost outlier cases except for inpatient services provided by a hospital transferring an inpatient to another hospital or post-acute care provider in accordance with section 9789.22(j); and) step 2 is simplified by referring to section 9789.21(f) which defines the term "costs".

Subdivision (f)(1)(B) is added to provide how inpatient services provided by a transferring hospital and the final discharging hospital will be reimbursed for cost outlier cases when an inpatient is transferred from one hospital to another hospital.

Subdivision (f)(1)(C) is added to provide how inpatient services (which are assigned to a qualifying DRG) provided by a hospital transferring an inpatient to a post-acute care provider (rehabilitation unit or hospital or long term hospital) is reimbursed for cost outlier cases.

Subdivision (f)(1)(D) is added to provide how inpatient services assigned to a special pay DRG provided by a hospital transferring an inpatient to a post-acute care provider is reimbursed for cost outlier cases.

Subdivision (f)(3) is amended to substitute "spinal device" for "spinal hardware" to conform to section 9789.21(v).

Subdivision (g) is amended to move the definition of spinal device from this subdivision to section 9789.21(v).

Subdivision (j)(1) is amended to clarify the term "average length of stay" is used as defined in section 9789.21(a).

6. Section 9789.23. Hospital Cost to Charge Ratios, Hospital Specific Outliers, and Hospital Composite Factors

This section is updated to incorporate by reference section 3133 of the Affordable Care Act, and section 1886(r) of the Social Security Act, and to conform to changes made by Medicare to the Inpatient Hospital Prospective Payment System.

7. Section 9789.25. Federal Regulations, Federal Register Notices, and Payment Impact File by Date of Discharge.

This section provides the updates to the federal regulation, federal register, and payment impact file references made in the Inpatient Hospital Fee Schedule in order to conform to changes in the Medicare payment system as required by Labor Code section 5307.1(g)(2).

Subdivision (a) is amended to incorporate by reference federal regulations that are referenced in the Inpatient Hospital Fee Schedule for discharges occurring on or after the effective date of the proposed amendments [30 days after the amendments are filed with the Secretary of State. Date to be inserted by OAL.]

Subdivision (b) is amended to incorporate by reference the federal register notices that are referenced in the Inpatient Hospital Fee Schedule for discharges occurring on or after the effective date of the proposed amendments [30 days after the amendments are filed with the Secretary of State. Date to be inserted by OAL.]

Subdivision (c) is amended to incorporate by reference the payment impact file that are referenced in the Inpatient Hospital Fee Schedule for discharges occurring on or after the effective date of the proposed amendments [30 days after the amendments are filed with the Secretary of State. Date to be inserted by OAL.]

8. Section 9789.50. Pathology and Laboratory

Subdivision (a) is amended to update the CMS' Clinical Diagnostic Laboratory Fee Schedule webpage address and the Division of Workers' Compensation webpage address.

Subdivision (c) is deleted to conform to Labor Code section 5307.1. Section 5307.1(e)(1) is no longer applicable, as the Administrative Director adopted a fee schedule for Pathology and Laboratory effective 2004.

9. Section 9789.60. Durable Medical Equipment, Prosthetics, Orthotics, Supplies

Subdivision (a) is amended to update the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) fee schedule webpage address and the Division of Workers' Compensation webpage address.

Subdivision (c) is deleted to conform to Labor Code section 5307.1. Section 5307.1(e)(1) is no longer applicable, as the Administrative Director adopted a fee schedule for Durable Medical Equipment, Prosthetics, Orthotics, Supplies, effective 2004.

10. Section 9789.70. Ambulance Services

Subdivision (a) is amended to update the CMS' Ambulance fee schedule webpage address and the Division of Workers' Compensation webpage address.

Subdivision (b) is deleted to conform to Labor Code section 5307.1. Section 5307.1(e)(1) is no longer applicable, as the Administrative Director adopted a fee schedule for Ambulance services effective 2004.

11. Section 9789.110. Update of Rules to Reflect Changes in the Medicare Payment System

This section is amended to update the DWC webpage address.

12. Section 9789.111. Effective Date of Fee Schedule Provisions

Subdivision (a) is amended to include the effective dates of the RBRVS-based physician fee schedule provisions (sections 9789.12.1-9789.19) that was adopted in response to SB 863 reforms, and to bring attention to the effective dates for the physician fee schedule set forth in Article 5.5 (sections 9790, et seq.).

Subdivision (b) is amended to conform to recent amendments made to the inpatient hospital fee schedule, and to reinforce what the effective dates are for the inpatient hospital fee schedule set forth in Article 5.5 (sections 9790, et seq.).

Subdivision (g) is amended to include a citation to section 9789.70 which is the regulation pertaining to the ambulance services fee schedule.

Section 9790. Authority

This section is amended to bring attention to the effective dates for the physician services and inpatient services provisions set forth in Article 5.5.

DISCLOSURES REGARDING THE PROPOSED REGULATORY ACTION

The Administrative Director has made the following initial determinations:

- Significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states: None. Adoption of these regulations reflects changes in the Medicare inpatient prospective payment system, to the extent practical, pursuant to Labor Code section 5307.1, and to clarify or conform to updates made to various sections of the OMFS.

- Adoption of these regulations will not: (1) create or eliminate jobs within the State of California, (2) create new businesses or eliminate existing businesses within the State of California, or (3) affect the expansion of businesses currently doing business in California.

- Effect on Housing Costs: None.

- The Acting Administrative Director is aware that there may be some cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action to modify the inpatient hospital operating disproportionate share adjustment methodology; and to provide a payment methodology for outlier cases that involve inpatient services provided by a hospital transferring an inpatient to another hospital or post-acute care provider. The proposed payment methodology for outlier cases is consistent with Medicare payment policies. The proposed regulations will most significantly affect hospitals, workers' compensation insurers, self-insured employers and workers' compensation third party administrators.

  Proposed amendment to modify the inpatient hospital operating DSH adjustment methodology: The proposed amendment is in response to changes Medicare has made to its operating DSH adjustment methodology for FY 2014. Under Medicare, the uncompensated care portion of the operating DSH payment (75% of the adjustment made to DSH qualified hospitals in base year 2013) will be adjusted to reflect changes in the percentage of individuals that are uninsured relative to uninsured individuals prior to application of section 3133 of the Affordable Care Act (base year 2013). It is anticipated the aggregate total payments for the uncompensated care portion of the operating DSH adjustment will be reduced with the coverage expansion under the Affordable Care Act. Medicare estimated the percent of individuals without insurance for FY 2014 (weighted average) to be 0.943. As a result, the aggregate payment for the uncompensated care costs portion of the DSH adjustment is 70.7 percent (the product of 75 percent and .943) of the amounts that would have been payable in 2013.

Originally, Medicare provided for a DSH adjustment to qualified hospitals for discharges occurring on or after May 1, 1986. The DSH adjustment is distributed through a hospital-specific add-on applied to the base DRG payment rates. Although there are two ways for a hospital to qualify for DSH adjustments, the primary method a hospital could qualify for a DSH adjustment was if it served a significantly disproportionate number of low-income patients. The hospital-specific DSH adjustment would be determined based on the disproportionate patient percentage using a number of different complex formulas. (According to MedPAC Report to Congress, March 2007, DSH adjustments are distributed on a basis of 10 different formulas.)

Section 3133 of the ACA revises the computation of the operating DSH adjustment as follows: 1. Instead of the amount that would otherwise be paid as the DSH adjustment, hospitals receive 25 percent of the amount determined under the current Medicare DSH payment method beginning in fiscal year (FY) 2014 for discharges occurring on or after October 1, 2013; and 2. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, becomes available for an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each hospital that qualifies for a DSH adjustment receives an uncompensated care payment (UCP) based on its share of insured low income days reported by all DSH qualified hospitals.

According to the March 2007 MedPAC Report to Congress, approximately 75 percent of hospitals covered by the Medicare acute inpatient PPS received a DSH adjustment in fiscal year 2004. The original justification for providing DSH adjustments was that low-income patients are more costly to treat, so that hospitals with a substantial share of low-income patients would likely experience higher costs than other similar institutions.

Under Medicare, the hospital's share of the uncompensated care pool is based on its share of low-income insured days to total low-income insured days across all hospitals eligible to receive DSH payments. The final payment will be determined during the settlement of the Medicare cost report. Medicare has converted the hospital's estimated share of the uncompensated care pool into a per discharge amount for *interim* payment purposes. This per discharge interim payment, however, is not appropriate for setting OMFS inpatient hospital allowances. In particular, the per discharge allowances for safety net hospitals that serve a high proportion of low-income insured patients but have relatively few Medicare discharges have an unreasonably high per discharge payment for uncompensated care costs.

Medicare's revisions to the DSH payment methodology requires an adjustment in how the maximum allowances are determined under the OMFS inpatient hospital fee schedule. If no amendments were made to the OMFS inpatient hospital fee schedule operating DSH payment methodology, the 2014 composite rate (and future year's composite rates) would include only 25 percent DSH payment for operating costs. Unless the DSH funds that are allocated to the uncompensated care pool are taken into account, allowances for hospitals that service a disproportionate share of low-income patients will be adversely affected. To determine a reasonable allowance, the proposed amendment to

the operating DSH adjustment would include the portion of the uncompensated care pool that is attributable to the DSH hospital. Using the Medicare adjustment for the expansion of covered individuals relative to 2013, the Acting Administrative Director is proposing to amend the operating DSH payment methodology to include 70.7 percent of the DSH amount that would have been payable under the pre-2014 formula. This amount would be added to the 25 percent that is already included in the composite rate resulting in a total DSH adjustment equivalent to 95.7 percent of the current adjustment. The DSH adjustment factor will be updated annually by Administrative Order to conform to Medicare changes.

Proposed amendment to conform to Medicare's cost outlier case payment methodology for hospitals transferring an inpatient to another hospital or post-acute care provider: Even though Medicare allows the transferring hospital to be paid a cost outlier payment, it has come to the Acting Administrative Director's attention that the current inpatient hospital fee schedule does not address whether inpatient services for cost outlier cases provided by a hospital transferring an inpatient to another hospital or post-acute care provider is eligible for an outlier payment, and if so, how the outlier payment would be calculated. The proposed amendment adopts Medicare's payment methodologies for these types of outlier cases. It is unclear how outlier transfer cases are currently handled. The Acting Administrative Director considered the overall volume of transfer cases, and the number of disputed claims. The Acting Administrative Director looked at the Independent Bill Review (IBR) cases with decisions. For cases with end dates of service in the first eleven months of 2013, there were no cases involving transferring hospitals, and only one outlier case. According to OSHPD patient discharge data for calendar year 2012, there was an estimated 0.32 percent of inpatient cases where an inpatient was transferred to another hospital, an estimated 0.76 percent of inpatient cases where an inpatient was transferred to another hospital or post-acute care provider with a discharge assigned to a qualifying DRG, and 0.17 percent with a discharge assigned to a special-pay DRG. The number of transfer cases that qualify for outlier payments, therefore, will be fraction of these transfer cases. Based on this information, the Acting Administrative Director believes the proposed amendment will have a negligible to no impact on businesses.

EFFECT ON SMALL BUSINESS

The Administrative Director has determined that the proposed regulations will have negligible effect on small business as there may be some reduced costs for operating DSH payments in 2014 and possibly negligible to no changes in costs due to the proposed amendments regarding transfer hospital outlier cases.

FISCAL IMPACTS

- Costs or savings to state agencies: These regulations affect the State Compensation Insurance Fund (SCIF), which is the largest workers' compensation insurer in the state. In 2013, SCIF had 10.81% of the workers' compensation market share (p.53, *2013 California P&C Market Share Report*, CA Dept. of Insurance, http://www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share/2013/upload/IndMktShr2013WP.pdf. SCIF may likely have similar

reduced costs for operating DSH payments in 2014 as other employers (approximate 4.3 percent) and negligible to no impact due to the proposed amendments regarding transfer hospital outlier cases.

- Costs/savings in federal funding to the State: None.

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The Acting Administrative Director has determined that the proposed regulations will not impose any new mandated programs or additional costs on any local agency or school district.

- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with section 17500) of Division 4 of the Government Code: None. The proposed regulations do apply to a local agency or school district in its capacity as an employer required to provide workers' compensation benefits to injured workers.

- **Other nondiscretionary costs/savings imposed upon local agencies:** Local agencies may likely have similar reduced costs for operating DSH payments in 2014 as other employers (approximate 4.3 percent) and negligible to no impact due to the proposed amendments regarding transfer hospital outlier cases.

CONSIDERATION OF ALTERNATIVES

The Acting Administrative Director invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

AVAILABILITY OF INITIAL STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, RULEMAKING FILE AND DOCUMENTS SUPPORTING THE RULEMAKING FILE / INTERNET ACCESS

The text of the proposed regulations and an Initial Statement of Reasons in plain English have been prepared and are available from the contact person named in this notice. The entire rulemaking file will be made available for inspection and copying at the address indicated below. However, documents subject to copyright may be inspected but not copied.

As of the date of this notice, the rulemaking file consists of this notice; the Initial Statement of Reasons; the proposed text of the regulations (underline and strikeout version); and the documents incorporated by reference. Also included are studies and documents relied upon in drafting the proposed regulations.

In addition, the Notice, Initial Statement of Reasons, and proposed text of regulations may be accessed and downloaded from the Division's website at http://www.dir.ca.gov/dwc/dwc_home_page.htm. To access them, click on the link for ''Participate in Rulemaking'' link and scroll down the list of rulemaking proceedings to find the current OMFS rulemaking link.

Any interested person may inspect a copy of the proposed regulations and any supplemental information contained in the rulemaking file. The rulemaking file will be available for inspection at the Department of Industrial Relations, Division of Workers' Compensation, 1515 Clay Street, 18th Floor, Oakland, California, between 9:00 a.m. and 4:30 p.m., Monday through Friday, unless the state office is closed for a state holiday. Copies of the proposed regulations, initial statement of reasons and any information contained in the rulemaking file may be requested in writing to the contact person.

CONTACT PERSON

Nonsubstantive inquiries concerning this action, such as requests to be added to the mailing list for rulemaking notices, requests for copies of the text of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person is:

Maureen Gray
Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142
E-mail: mgray@dir.ca.gov

The telephone number of the contact person is (510) 286-7100.

BACKUP CONTACT PERSON

In the event the contact person is unavailable, inquiries should be directed to the following backup contact person:

Jarvia Shu, Industrial Relations Counsel
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142
E-mail: (jshu@dir.ca.gov)

The telephone number of the backup contact persons is (510) 286-7100.

AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING

If the Acting Administrative Director makes changes to the proposed regulations as a result of the public hearing and public comment received, the modified text with changes clearly indicated will be made available for public comment for at least 15 days prior to the date on which the regulations are adopted.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

Upon its completion, the Final Statement of Reasons will be available and copies may be requested from the contact person named in this notice or may be accessed on the website: http://www.dir.ca.gov/dwc/dwc_home_page.htm, then click on the link for ‘‘Participate in Rulemaking’’ link and scroll down the list of rulemaking proceedings to find the current OMFS rulemaking link.

AUTOMATIC MAILING

A copy of this Notice will automatically be sent to those interested persons on the Acting Administrative Director’s mailing list.

If adopted, the regulations as amended and adopted will appear in title 8, California Code of Regulations, commencing with section 9789.10.