STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

INITIAL STATEMENT OF REASONS

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

TITLE 8, CALIFORNIA CODE OF REGULATIONS

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 Initial Statement of Reasons and the accompanying Notice of Rulemaking 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.

BACKGROUND TO REGULATORY PROCEEDING

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 , 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.

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.

- 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.

NECESSITY

The Acting Administrative Director has determined that amendments to sections 9789.10, 9789.11, 9789.20, 9789.21, 9789.22, 9789.111, and 9790 are necessary to address the misapplication of the effective dates of various fee schedule provisions. Even though the proposed amendments are declaratory of existing laws, the proposed amendments reiterate or clarify the applicable dates of fee schedule provisions.

The Acting Administrative Director proposes amendments to sections 9789.50 (Pathology and Laboratory), 9789.60 (Durable Medical Equipment, Prosthetics, Orthotics, Supplies), and 9789.70 (Ambulance Services) to conform to Labor Code section 5307.1. Each of these fee schedules includes a subdivision which provides that the maximum payment for services not covered by the relevant Medicare payment system shall not exceed the fee specified in the OMFS 2003. These provisions were adopted to conform to section 5307.1(e)(1) of the Labor Code, which states, "*Prior* to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003, except as otherwise provided in this subdivision." (Emphasis added.) However, section 5307.1(e)(1) is no longer applicable, as the Administrative Director adopted fee schedules for Pathology and Laboratory, Durable Medical Equipment, Prosthetics, Orthotics, Supplies, and Ambulance Services for services effective January 2, 2004. Therefore, the Acting Administrative Director proposes to delete the provisions from the above-referenced fee schedule regulations. The Acting Administrative Director also proposes minor amendments required to conform to the proposed changes, to update or clarify sections of the Official Medical Fee Schedule.

Finally, the Acting Administrative Director has determined that amendments to the Inpatient Hospital Fee Schedule (sections 9789.20 - 9789.25) are necessary to address two different payment methodology issues. One of the proposed amendments addresses modification to the operating disproportionate share hospital (DSH) adjustment which is necessary as a result of changes made by Medicare to their operating DSH adjustment methodology. The other proposed amendment is necessary because 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 cases that qualify. The proposed amendments will provide the methodology for determining whether a transfer 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 for outlier transfer cases.

TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS

The Acting Administrative Director relied upon the following technical, theoretical, or empirical studies, reports, decisions or similar documents in proposing the above-identified regulations:

(1) *2013 California P&C Market Share Report*, California Department of Insurance.
(2) *Clarification of Medicare's Transfer Policy Under the Inpatient Prospective Payment System (IPPS)*, Medicare Learning Network (MLN) Matters Number SE0459
(3) Dobson, A., El-Gamil, A., Shimer, M., Pick, A., Reuter, K., DaVanzo, J. of Dobson/DaVanzo and Koenig, L., Sankaran, S. of KNG Health Consulting, LLC,

Improvements to Medicare Disproportionate Share Hospital (DSH) Payments, Final Report (HHSM-500-2011-00014; Task Order HHSM-500-TO001), April 25, 2013
(4) *Medicare Claims Processing Manual, Chapter 3 – Inpatient Hospital Billing,* CMS.
(5) *Medicare Disproportionate Share Hospital,* Medicare Learning Network (MLN) Matters Fact Sheet, December 2013
(6) *Report to the Congress: Medicare Payment Policy,* Medicare Payment Advisory Commission (MedPAC), March 2007

SPECIFIC TECHNOLOGIES OR EQUIPMENT REQUIRED (if applicable)

No specific technologies or equipment are required by these proposed regulations.

FACTS ON WHICH THE AGENCY RELIES IN SUPPORT OF ITS INITIAL DETERMINATION THAT THE REGULATIONS WILL NOT HAVE A SIGNIFICANT ADVERSE IMPACT ON BUSINESS

The Acting Administrative Director has determined that these proposed regulations will not have a significant adverse impact on business. The proposed inpatient hospital fee schedule regulations will reduce the amount of operating DSH payment adjustment made to qualified hospitals as the total operating DSH adjustment will be equivalent to 95.7 percent of the current adjustment. The proposed regulations also include payment methodologies for determining the outlier payment for hospitals transferring patients to another hospital or post-acute care providers. The Acting Administrative Director believes this proposed amendment will have negligible to no impact on businesses.

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 an operating DSH adjustment to qualified hospitals for discharges occurring on or after May 1, 1986. The operating DSH adjustment is distributed through a hospital-specific add-on applied to the base DRG payment rates. Although there is two ways for a hospital to qualify for operating DSH adjustments, the primary method a hospital could qualify for the adjustment was if it served a significantly

disproportionate number of low-income patients. The hospital-specific operating 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 operating DSH adjustment, hospitals receive 25 percent of the amount determined under the current Medicare operating 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 operating 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 an operating 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 prospective payment system 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 otherwise 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 operating 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 operating 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 operating DSH adjustment equivalent to 95.7 percent of the current adjustment. The operating 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 Administrator 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.

In conclusion, the impacts to the workers' compensation community will be as follows:

Workers' compensation insurers, self-insured employers and workers' compensation third party administrators will not experience any changes in how to determine payment for operating DSH adjustments because the hospital-specific operating DSH adjustment will continue to be provided as part of the annual update of the inpatient hospital fee schedule. Operating DSH adjustments will experience an overall decrease in payment amount equivalent to 95.7 percent of the current operating DSH adjustment. The proposed amendments to the inpatient hospital fee schedule also clarify that outlier payments are allowable for inpatient services provided by transferring hospitals. This clarification to the regulation should reduce potential disputes. Based on the information considered, the Acting Administrative Director believes the proposed amendment will have a negligible to no impact on businesses. Finally, amendments to the OMFS which reiterate the effective dates of the various fee schedule provisions will reduce the

potential of disputes pertaining to the proper application of a fee schedule based on date of service or discharge.

SECTION 9789.10 – Physician Services – Definitions

Specific Purpose: The proposed amendment to section 9789.10 will add the applicable dates of service to the title of this section. This section is applicable to physician services rendered on or after July 1, 2004, but before January 1, 2014.

Necessity: Even though the proposed amendment is declaratory of existing laws, it is necessary to add the applicable dates to the title of the physician fee schedule provision because the Acting Administrative Director has become aware of the misapplication of the effective dates of various fee schedule provisions.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

SECTION 9789.11 - Physician Services Rendered on or After July 1, 2004

Specific Purpose: The proposed amendments to section 9789.11 will add the applicable dates of service to subdivisions (a), (b), (d)(1), (d)(2), (e), (f), and to the title of this section. This section is applicable to physician services rendered on or after July 1, 2004, but before January 1, 2014.

Necessity: Even though the proposed amendment is declaratory of existing laws, it is necessary to add the applicable dates of the section title and the subdivisions because the Acting Administrative Director has become aware of the misapplication of the effective dates of various fee schedule provisions.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

SECTION 9789.20-General Information for Inpatient Hospital Fee Schedule—Discharge On or After July 1, 2004

<u>Section 9789.20(b):</u>

Specific Purpose: The proposed amendment will add the applicable dates of service for charges made by a hospital for the professional component of medical services. Physician services rendered on or after January 1, 2014, shall be paid according to Sections 9789.12.1 through 9789.19. Services rendered on or after July 1, 2004 but before January 1, 2014 shall be paid according to Sections 9789.10 through 9789.11. Services rendered after January 1, 2004 but before July 1, 2004 are governed by the "emergency"

regulations that were effective on January 2, 2004. Services rendered on or before January 1, 2004 will be paid according to Section 9790, et seq.

Necessity: It is necessary to add the applicable dates of the physician fee schedule provisions to reflect the RBRVS-based physician fee schedule (sections 9789.12.1 through 9789.19) that was recently adopted for dates of service on or after January 1, 2014. In addition, the applicable dates for all of the other physician fee schedule provisions are set forth in this subdivision for added clarity.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

Sections 9789.20(d) and (e):

Specific Purpose: The proposed amendments update the Division of Workers' Compensation webpage address.

Necessity: It is necessary to update the Division of Workers' Compensation webpage address to provide the current webpage address.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

SECTION 9789.21-Definitions for Inpatient Hospital Fee Schedule –

Section 9789.21(b):

Specific Purpose: Subdivision 9789.21(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".

Necessity: This amendment is necessary to correct the clerical error.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

Section 9789.21(e)(1)(A):

Specific Purpose: Subdivision 9789.21(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.

Necessity: This amendment is necessary to correct the clerical error.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

Section 9789.21(e)(2)(E):

Specific Purpose: 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. OAL to insert date in regulation], the OMFS operating 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.

Necessity: The proposed amendments are necessary as a result of changes made by Medicare to their operating DSH adjustment methodology for FY 2014. Generally, 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 that 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.

In particular, the proposed amendment of section 9789.21(e)(2)(E) modifies the operating disproportionate share adjustment methodology because Medicare has revised the Medicare Inpatient Prospective Payment System (IPPS) DSH payment policy for operating costs (DSH adjustments) as required by Section 3133 of the Affordable Care Act of 2010 (ACA) for discharges occurring on or after October 1, 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 is 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 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 (UCP) 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 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 otherwise 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 proposed amendment to the operating DSH payment methodology would include 70.7 percent of the operating 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 operating DSH adjustment equivalent to 95.7 percent of the current adjustment. The operating DSH adjustment factor will be updated annually by Administrative Order to conform to Medicare changes.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

Section 9789.21(f):

Specific Purpose: This amendment is 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.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable. How costs are determined is set forth in both sections 9789.21(f) and 9789.22(f)(1)(A). The proposed amendment will set forth how costs are determined in one section of the fee schedule (section 9789.21(f)), and clarify how to calculate costs, especially when the procedure includes spinal devices. It has come to the Acting Administrative Director's attention that without continuing to require proof of documented paid costs for spinal devices, the hospital is not required to provide the payer their basis for how it charges for spinal devices. The Acting Administrative Director is aware of examples where a facility has charged in excess of $200,000 for spinal implants in a spinal surgery DRG, without providing the payer the required documentation of paid costs. Therefore, this proposed amendment will reiterate and clarify the continuing requirement that the facility provide the payer with documented paid cost for spinal devices.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(v):

Specific Purpose: It is proposed to add this subdivision in order to move the definition of "spinal device" from section 9789.22(g) to this section (Definitions of Inpatient Hospital Fee Schedule).

Necessity: This proposed subdivision is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed addition.

Section 9789.21(w formerly v):

Specific Purpose: The proposed amendment is to re-letter the subdivision.

Necessity: This proposed amendment is necessary to conform lettering to proposed changes to the regulatory text.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed addition.

SECTION 9789.22-Payment of Inpatient Hospital Services

Section 9789.22(d):

Specific Purpose: This subdivision is amended to update references to the physician fee schedule provisions. This subdivision makes reference to section 9789.111(a) which sets forth effective dates for physician fee schedule provisions including the adoption of the Resource Based Relative Value Scale (RBRVS)-based 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).

Necessity: This amendment is necessary to update the inpatient hospital fee schedule to reflect the RBRVS-based physician fee schedule provisions effective for physician services rendered on or after January 1, 2014.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(f)(1)

Specific Purpose: Section 9789.33(f)(1) is amended to re-designate the current regulatory language as subdivision (A) and to add subdivisions (B through D).

Necessity: 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 cases that qualify. The proposed amendments will provide the methodology for determining whether a transfer case is eligible for an outlier payment, and if so, how the payment amount would be calculated.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(f)(1)(A)

Specific Purpose: This subdivision is amended: 1) to 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 2) to simplify step 2 by referring to section 9789.21(f) which defines the term "costs".

Necessity: This amendment is necessary to clarify when this methodology is to be used to determine whether a case qualifies for an outlier payment. The amendment also simplifies and eliminates confusion on how costs are determined.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(f)(1)(B):

Specific Purpose: This subdivision 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.

Necessity: This amendment adopts the Medicare methodology for determining outlier eligibility and outlier payment for inpatient services provided by a transferring hospital and final discharging hospital when an inpatient is transferred from one hospital to another hospital. Labor Code section 5307.1(a)(1) states in pertinent part that, "…all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems…".

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(f)(a)(C):

Specific Purpose: This subdivision is added to provide how inpatient services 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.

Necessity: This amendment adopts the Medicare methodology for determining outlier eligibility and outlier payment for inpatient services provided by a transferring hospital when an inpatient is transferred from one hospital to post-acute care provider and the patient discharged is assigned a qualifying DRG. Labor Code section 5307.1(a)(1) states in pertinent part that, "…all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems…".

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(f)(1)(D):

Specific Purpose: This subdivision 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.

Necessity: This amendment adopts the Medicare methodology for determining outlier eligibility and outlier payment for inpatient services assigned to a "special pay DRG" provided by a hospital transferring an inpatient to a post-acute care provider. Labor Code section 5307.1(a)(1) states in pertinent part that, "…all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems…".

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(f)(3):

Specific Purpose: subdivision is amended to substitute "spinal device" for "spinal hardware" to conform to section 9789.21(v).

Necessity: This amendment is necessary so that the terminology is consistent with the definitions section of the inpatient hospital fee schedule (section 9789.21(v)).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(g):

Specific Purpose: This subdivision is amended to move the definition of spinal device from this subdivision to section 9789.21(v).

Necessity: This amendment moves the definition of spinal device to the definitions section of the inpatient hospital fee schedule (section 9789.21) to make the fee schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(j)(1):

Specific Purpose: This subdivision is amended to clarify the term "average length of stay" is used as defined in section 9789.21(a), which states, ""Average length of stay" means the geometric mean length of stay for a diagnosis-related group assigned by CMS.".

Necessity: This amendment is necessary to lessen confusion by calling the reader's attention to how the term "average length of stay" is used.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

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

Specific Purpose: This section is amended 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.

Necessity: This amendment is necessary to bring this subdivision into conformance with changes to the Medicare inpatient hospital prospective payment system.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

SECTION 9789.25 Federal Regulations, Federal Register Notices, and Payment Impact File by Date of Discharge

Section 9789.25(a):

Specific Purpose: This subdivision 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. OAL to insert date in regulation text.]

Necessity: This amendment is necessary to bring the inpatient hospital fee schedule regulations into conformance with changes to the Medicare inpatient hospital prospective payment system. Labor Code section 5307.1(a)(1) states in pertinent part that, "…all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems…".

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.25(b):

Specific Purpose: This subdivision 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. OAL to insert date in regulation text]. A new category, "Uncompensated Care Adjustment" is added to this section.

Necessity: This amendment is necessary to bring the inpatient hospital fee schedule regulations into conformance with changes to the Medicare inpatient hospital prospective payment system. Labor Code section 5307.1(a)(1) states in pertinent part that, "…all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems…".

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.25(c):

Specific Purpose: This subdivision 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. OAL to insert date in regulation text].

Necessity: This amendment is necessary to bring the inpatient hospital fee schedule regulations into conformance with changes to the Medicare inpatient hospital prospective payment system. Labor Code section 5307.1(a)(1) states in pertinent part that, "…all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems…".

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

SECTION 9789.50. Pathology and Laboratory

Section 9789.50(a):

Specific Purpose: The proposed amendment updates CMS' Clinical Diagnostic Laboratory Fee Schedule webpage address and the Division of Workers' Compensation webpage address.

Necessity: It is necessary to update CMS' Clinical Diagnostic Laboratory Fee Schedule webpage address and Workers' Compensation webpage address to provide the current web addresses.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

Section 9789.50(c):

Specific Purpose: This subdivision is deleted.

Necessity: This amendment is necessary 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 for services rendered after January 1, 2004.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

SECTION 9789.60. Durable Medical Equipment, Prosthetics, Orthotics, Supplies

Section 9789.60(a):

Specific Purpose: The proposed amendment updates CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule webpage address and the Division of Workers' Compensation webpage address.

Necessity: It is necessary to update CMS' DMEPOS Fee Schedule webpage address and Workers' Compensation webpage address to provide the current web addresses.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

Section 9789.60(c):

Specific Purpose: This subdivision is deleted.

Necessity: This amendment is necessary 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 for services rendered after January 1, 2004.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

SECTION 9789.70. Ambulance Services

Section 9789.70(a):

Specific Purpose: The proposed amendment updates CMS' Ambulance Fee Schedule webpage address and the Division of Workers' Compensation webpage address.

Necessity: It is necessary to update CMS' Ambulance Fee Schedule webpage address and Workers' Compensation webpage address to provide the current web addresses.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

Section 9789.70(b):

Specific Purpose: This subdivision is deleted.

Necessity: This amendment is necessary 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 for services rendered after January 1, 2004.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

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

Specific Purpose: This section is amended to update the DWC webpage address.

Necessity: This amendment is necessary to provide the current DWC webpage address.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

SECTION 9789.111. Effective Date of Fee Schedule Provisions

Section 9789.111(a):

Specific Purpose: This subdivision 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.).

Necessity: This amendment is necessary to bring this subdivision into conformance with changes to the OMFS physician fee schedule for services rendered on or after January 1, 2014. In addition, even though the proposed amendments are declaratory of existing laws, it is also necessary to amend this subdivision (and other fee schedule sections in Article 5.3) and section 9790 in Article 5.5, to reiterate, the applicable dates of fee schedule provisions, because the Acting Administrative Director has become aware of the misapplication of the effective dates of various fee schedule provisions.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.111(b):

Specific Purpose: This subdivision 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.).

Necessity: This amendment is necessary to bring this subdivision into conformance with changes made to the OMFS inpatient hospital fee schedule. In addition, even though the proposed amendments are declaratory of existing laws, it is necessary to amend this subdivision to reiterate the applicable dates of inpatient hospital fee schedule provisions in Article 5.5 (sections 9790, et seq.), because the Acting Administrative Director has become aware of the misapplication of the effective dates for this fee schedule.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.111(g):

Specific Purpose: This subdivision is amended to include a citation to section 9789.70 which is the regulation pertaining to the ambulance services fee schedule.

Necessity: This amendment is necessary to include a citation to the ambulance services fee schedule regulation, to provide specificity and clarification.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

SECTION 9790. Authority

Specific Purpose: 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.

Necessity: Even though the proposed amendment is declaratory of existing laws, it is necessary to amend this subdivision to reiterate the applicable dates for the physician services and inpatient hospital services provisions set forth in Article 5.5 (sections 9790, et seq.), because the Acting Administrative Director has become aware of the misapplication of the effective dates for the fee schedule provisions in Article 5.5.

Consideration of Alternatives: At this time, the Acting Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.