STATE PLAN UNDER TITLE XIX OF SOCIAL SECURITY ACT
STATE California

The policy of the State Agency is that reimbursement for each of the other types of care or service listed in Section 1905(a) of the Act that are included in the program under the plan will be at the lesser of usual charges or the limits specified in the California Code of Regulations (CCR), Title 22, Division 3, Chapter 3, Article 7 (commencing with Section 51501) and CCR, Title 17, Chapter 4, Subchapter 13, Sections 6800-6874, for EPSDT health assessment services, or as specified by any other means authorized by state law.

The methodology utilized by the State Agency in establishing payment rates will be as follows:

(a) The development of an evidentiary base or rate study resulting in the determination of a proposed rate.

(b) To the extent required by State or Federal law or regulations, the presentation of the proposed rate at public hearing to gather public input to the rate determination process.

(c) The determination of a payment rate based on an evidentiary base, including pertinent input from the public.

(d) The establishment of the payment rate through the State Agency's adoption of regulations specifying such rate in the CCR, Title 22, Division 3, Chapter 3, Article 7 (commencing with Section 51501), and CCR, Title 17, Chapter 4, Subchapter 13, commencing with Section 6868, Schedule of Maximum Allowances for EPSDT health assessment, or through any other means authorized by State law.

State: California

(e) Notwithstanding any other provisions of this Attachment to the State Plan pertinent to the methods and levels of reimbursement to providers, rates may be adjusted when required by state statute provided that applicable requirements of 42 CFR Part 447 are met.

(f) (1) In addition, at the beginning of each fiscal year, for the current fiscal year, the director shall establish a monthly schedule of anticipated total payments and anticipated payments for categories of services, according to the categories established in the Governor's Budget. The schedule will be revised quarterly. The director shall report actual total payments and payments for the categories of services monthly to the Director of Finance and to the Joint Legislative Budget Committee.

(2) At any time during the fiscal year, if the director has reason to believe that the total cost of the program will exceed available funds, the director may, first modify the method or amount of payment for services provided that no amount shall be reduced more than 10 percent and no modification will conflict with federal law. At any time during the fiscal year, if the total amounts paid since the beginning of the fiscal year exceed by 10 percent the amounts scheduled, the director shall immediately institute such modification.

(3) At any time during the fiscal year, if the total amount paid for any category of service in the Governor's Budget exceeds by 10 percent the amounts scheduled for that category of service (other than services for which the method or amount of payment is prescribed by the United States Secretary of Health and Human Services pursuant to Title XIX of the federal Social Social Security Act), the director shall modify the method or amount of payment for such category of service to assure that the total amount paid for such category of service in the fiscal year shall be less than 10 percent in excess of the total amount scheduled for the fiscal year for that category of service, provided the total cost of the program to the State General Fund will not exceed appropriated state general funds. If, on the other hand, the director has reason to believe that the total cost of the program to the State General Fund will exceed appropriated state general funds, the method or amount of payment may be further modified as provided in subparagraph (2).

State: California

(4) No modification in method or amount of payment will be made under this paragraph which does not meet all applicable requirements of 42 CFR Part 447. An analysis of provider participation, and the expected impact of any proposed modification on provider participation, will be completed before any modification of payments is made under this paragraph. Where necessary, adjustments to proposed or implemented modifications in method or amount of payment made under this paragraph will be made, to assure compliance with 42 CFR 447.204.

(5) Before any of the above actions are taken, the director shall consult with representatives of concerned provider groups.

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

6) For dates of service on or after July 1, 2008, through and including February 28, 2009, reimbursement for the following outpatient services described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B are reduced by ten percent:

- Outpatient hospital services rendered in and billed by hospital outpatient departments, as described in Attachment 3.1-A, section 2a.
- Emergency medical transportation, as described in Attachment 3.1-A, section 24a, and in Attachment 3.1-B, section 23a.
- Non-drug services provided by a pharmacy, as described in Attachment 3.1-A, including but not limited to sections 7c.1 through 7c.4.
- Providers and services included in Supplement 15 to this Attachment.

The outpatient provider types and services specified below are exempt from the ten percent reduction:

- Services provided and billed by Physicians, as described in Attachment 3.1-A, section 5a.
- Services provided and billed by Clinics, as described in Attachment 3.1-A, section 9.
- Services provided and billed by Optometrists, as described in Attachment 3.1-A, section 6b.
- Services provided and billed by Dentists, as described in Attachment 3.1-A, section 10.

(7) For dates of service on or after July 1, 2008, through and including November 16, 2008, reimbursement for the following outpatient services described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B are reduced by ten percent:

- Nonemergency medical transportation services, as described in Attachment 3.1-A, section 24a, and in Attachment 3.1-B, section 23a.
- Home health services, as described in Attachment 3.1-A, section 7 (refer to rates on page 20a in this Attachment).

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

(8) For dates of service on or after March 1, 2009, reimbursement for the following outpatient services described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B are reduced by one percent:

- Any and all services provided and billed by Physicians and Clinics to beneficiaries less than age 21, as described in Attachment 3.1-A, sections 5a and 9.
- Home health services, as described in Attachment 3.1-A, section 7 (refer to rates on page 20a in this Attachment).

(9) For dates of service on or after March 1, 2009, through and including May 31, 2011, reimbursement for outpatient services described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B will be reduced by one percent. Providers and services subject to this reduction include:

- Any and all services provided and billed by Physicians and Clinics to beneficiaries aged 21 and older, as described in Attachment 3.1-A, sections 5a and 9.
- Medical transportation (emergency and nonemergency), as described in Attachment 3.1-A, section 24a, and in Attachment 3.1-B, section 23a.
- Services provided and billed by Optometrists, as described in Attachment 3.1-A, section 6b.
- Services provided and billed by Dentists, as described in Attachment 3.1-A, section 10.
- Providers and services included in Supplement 15 of this Attachment.

(10) For dates of service on or after March 1, 2009, through and including April 5, 2009, and dates of service on or after January 1, 2011, through and including April 12, 2011, reimbursement for outpatient hospital services set forth in Attachment 3.1-A, section 2a, rendered in and billed by a hospital outpatient department, described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B, are reduced by one percent.

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

(11) For dates of service on or after March 1, 2009, through and including May 31, 2011, reimbursement for non-drug services provided by a pharmacy, set forth in Attachment 3.1-A, including but not limited to sections 7c.1 through 7c.4, otherwise payable in accordance with the methods and standards described on page 1 in this Attachment 4.19-B, are reduced by five percent.

(12) The payment reductions provided in paragraphs (6) and (10) to hospital outpatient department services set forth in Attachment 3.1-A, section 2a, provided and billed by small and rural hospitals, as defined in Section 124840 of California's Health and Safety Code, will be implemented as follows:

- For dates of service provided on or after July 1, 2008, through and including October 31, 2008, a ten percent payment reduction will apply.
- For dates of service provided on or after November 1, 2008, through and including December 31, 2010, no payment reduction will apply.
- For dates of service provided on or after January 1, 2011, through and including April 12, 2011, a one percent payment reduction will apply.
- For dates of service provided on or after April 13, 2011, no payment reduction will apply.

(13) The payment reductions specified in paragraphs (6) through (12) do not apply to supplemental payments and only apply to the basic Medi-Cal reimbursement rate.

(14) The payment reductions specified in paragraphs (6) through (12) apply only to those services described in Attachment 3.1-A entitled, Amount, Duration, and Scope of Medical and Remedial Care and Service Provided to the Categorically Needy and Attachment 3.1-B entitled, Amount, Duration and Scope of Services Provided Medically Needy Group(s), which are billed to the Department directly by the provider that rendered the service.

(15) The payment reductions specified in paragraphs (6) through (12), set forth on pages 3.1 through 3.4 do not apply to the following provider types and services:

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

- Federally qualified health center services, described in Attachment 3.1-A, sections 2c and 2d, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1115 of the federal Social Security Act.
- Rural health clinic services, as described in Attachment 3.1-A, section 2b.
- Payments to facilities owned or operated by the State Department of Mental Health for psychology services, as defined in Attachment 3.1-A, section 6d.1 or to the State Department of Developmental Services for targeted case management services, as defined in Attachment 3.1-A, section 19.
- Services provided by local education agencies, as described in Attachment 3.1-A, section 24g, and Attachment 3.1-B, section 23g.
- Breast and cervical cancer treatment services, including but not limited to diagnostic, screening, and treatment services related to breast and cervical cancer, as described in Attachment 3.1-A, sections 2a and 5a.
- Family planning services and supplies, as described in Attachment 3.1-A, item 4c, provided by the Family Planning, Access, Care, and Treatment (Family PACT) Program.
- Hospice services, as described in Attachment 3.1-A, section 18.

(16) The effect of the payment reductions in paragraphs (6) through (12) will be monitored in accordance with the monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services".

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

(17) The effect of the payment reductions in paragraphs (6) through (13) will be monitored in accordance with the monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services".

(18) For dates of service on or after April 1, 2012, the payment reductions specified in paragraph (13), at page 3.3, do not apply to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, as described in Attachment 3.1-A, section 4b, when those services are provided and billed by Pediatric Day Health Care facilities.

REIMBURSEMENT METHODOLOGY FOR ESTABLISHING REIMBURSEMENT RATES FOR DURABLE MEDICAL EQUIPMENT, ORTHOTIC AND PROSTHETIC APPLIANCES, AND LABORATORY SERVICES

1. The methodology utilized by the State Agency in establishing reimbursement rates for durable medical equipment as described in State Plan Attachment 3.1-A, paragraph 2a, entitled "Hospital Outpatient Department Services and Organized Outpatient Clinic Services", and Paragraph 7c.2, entitled "Home Health Services Durable Medical Equipment", will be as follows:

   (a) Reimbursement for the rental or purchase of durable medical equipment with a specified maximum allowable rate established by Medicare, except wheelchairs, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, shall be the lesser of the following:

      (1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1, entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public or the net purchase price of the item (as documented in the provider's books and records), plus no more than a 100 percent mark-up. (Refer to Reimbursement Methodology table at page 3e.)

      (2) An amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service. (Refer to Reimbursement Methodology Table at page 3e.)

   (b) Reimbursement for the rental or purchase of a wheelchair, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, with a specified maximum allowable rate established by Medicare shall be the lowest of the following:

      (1) The amount billed in accordance with California Code of Regulations, Title 22, Section 51008.1 entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item (as documented in the provider's books and records),

plus no more than a 100 percent mark-up. (Refer to Reimbursement Methodology Table at page 3e.)

(2) An amount that does not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar service. (Refer to Reimbursement Methodology Table at page 3e.)

(c) Reimbursement for the rental or purchase of all durable medical equipment billed to the Medi-Cal program utilizing HCPCS codes with no specified maximum allowable rate (either non-covered by Medicare or Medicare did not establish a reimbursement rate), except wheelchairs, wheelchair accessories, and wheelchair replacement parts, shall be the lowest of the following:

(1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1 entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item, (as documented in the provider's books and records) plus no more than 100 percent mark-up. (Refer to Reimbursement Methodology Table at page 3e.)

(2) The actual acquisition cost plus a markup to be established by the State Agency based on rate studies and periodic reviews to provide a reasonable reimbursement and maintain adequate access to care. (Refer to Reimbursement Methodology Table at page 3e.)

(3) The manufacturer's suggested retail purchase price, documented by a printed catalog or hard copy of an electronic catalog page published on a date defined by Welfare and Institution Code section 14105.48, reduced by a percentage discount of 20 percent. (Refer to Reimbursement Methodology Table at page 3e.)

(d) Reimbursement for the rental or purchase of wheelchairs, wheelchair accessories, and wheelchair replacement parts billed to the Medi-Cal program utilizing codes with no specified maximum allowable rate (either non-covered by Medicare or Medicare did not establish a reimbursement rate) shall be the lowest of the following:

(1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1 entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item, (as documented in the provider's books and records) plus no more than 100 percent mark-up. (Refer to Reimbursement Methodology Table at page 3e.)

(2) The actual acquisition cost plus a markup to be established by the State Agency based on rate studies and periodic review to assure adequate reimbursement and access to care. (Refer to Reimbursement Methodology Table at page 3e.)

(3) The manufacturer's suggested retail purchase price, documented by a printed catalog or a hard copy of an electronic catalog page published on a date defined by Welfare and Institutions Code section 14105.48, reduced by a percentage discount of 20 percent, or by 15 percent if the provider employs or contracts with a qualified rehabilitation professional. (Refer to Reimbursement Methodology at page 3f.)

(e) Reimbursement for the purchase of all durable medical equipment supplies and accessories without a specified maximum allowable rate (either non-covered by Medicare or Medicare did not establish a reimbursement rate), and which are not described in subparagraphs (a) – (d) above, shall be the lesser of the following:

(1) The amount billed in accordance with California Code of Regulations, Title 22, Section 51008.1 entitled (Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item (as documented in the provider's books and records) plus no more than 100 percent mark-up. (Refer to Reimbursement Methodology Table at page 3f.)

(2) The acquisition cost for the item, plus a 23 percent markup. (Refer to Reimbursement Methodology Table at page 3f.)

2. Except as otherwise noted in the plan, State developed fee schedule rates established in accordance with Attachment 4.19-B, beginning on page 3a, are the same for both governmental and private providers of DME and the fee

schedule and any annual or periodic adjustments to the fee schedule are published in the provider manual and on the California Department of Health Services Medi-Cal website.

3. Reimbursement rates for orthotic and prosthetic appliances as described in State Plan Attachment 3.1-A, paragraph 12c, entitled "Prosthetic and Orthotic Appliances," shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item. (Refer to Reimbursement Methodology Table at page 3f.)

4. Reimbursement rates for clinical laboratory or laboratory services as described in State Plan Attachment 3.1-A, paragraph 3, entitled "Laboratory, Radiological, and Radioisotope Services," shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar service. (Refer to Reimbursement Methodology Table at page 3f.)

Reimbursement Methodology Table

Paragraph	Effective Date	Percentage	Authority
1(a)(1), (b)(1), (c)(1), (d)(1), (e)(1)	August 28, 2003	No more than 100 percent markup	California Code of Regulations, title 22, section 51008.1
1(a)(2)	October 1, 2003	Does not exceed 80% of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service	California Welfare and Institutions Code section 14105.48
1(b)(2)	October 1, 2003	Does not exceed 100% of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service	California Welfare and Institutions Code section 14105.48
1(c)(2)	November 1, 2003	The acquisition cost plus a 67% markup	Rate Study
1(c)(3)	November 1, 2003	The manufacturer's suggested retail purchase price reduced by a percentage discount of 20%	California Welfare and Institutions Code section 14105.48
1(d)(2)	January 1, 2004	The acquisition cost plus a 67% markup	Rate Study

Reimbursement Methodology Table

Paragraph	Effective Date	Percentage	Authority
1(d)(3)	January 1, 2004	The manufacturer's suggested retail purchase price reduced by a percentage discount of 20%, or by 15% if the provider employs or contracts with a qualified rehabilitation professional	California Welfare and Institutions Code section 14105.48
1(e)(2)	October 1, 2003	The acquisition cost plus a 23% markup	California Welfare and Institutions Code section 14105.48
3	October 1, 2003	May not exceed 80% of the lowest maximum allowance for California established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.21
4	October 1, 2003	May not exceed 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Terrirory California

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES (OTHER THAN INPATIENT HOSPITAL, AND LONG TERM CARE FACILITIES).

X Case Management Services

See Case Management Rates (Attached).

Reimbursement Unit of Services

For client data purposes and research, a case management unit of service is defined by DMH as a face-to-face or telephone contact with a client, regardless of the length of time. That contact is documented in the client case management record and, ultimately, reported to the State as part of the Client Data System. For purposes of cost analysis, rate development, and reimbursement, the case management unit of service is defined as a service period (accumulated contacts with the client, the client's family, significant others, and care providers) of fifteen minutes; partial units of time are rounded to the nearest quarter-hour increment. The unit of time serves as the basis for reimbursement for both Short-Doyle (State funds only) and SD/MC (State funds and FFP).