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

REIMBURSEMENT TO SPECIFIED GOVERNMENT-OPERATED PROVIDERS FOR COSTS OF PROFESSIONAL SERVICES

This segment of Attachment 4.19-B provides reimbursement to eligible government-operated hospitals or the government entities with which they are affiliated (including affiliated government-operated physician practice groups), for the uncompensated Medicaid costs of providing physician and non-physician practitioner professional services to Medi-Cal beneficiaries. Only the otherwise uncompensated costs of professional services not claimed by the hospital as Medicaid inpatient hospital services under the hospital's provider number, or not otherwise recognized under the methodology set forth on page 46 et seq. of Attachment 4.19-A, the methodology for cost-based reimbursement under Supplement 5, or the methodologies for supplemental reimbursement for government operated outpatient hospital services or government operated clinic services set forth in other sections of this Attachment 4.19-B, are eligible for reimbursement under this segment of Attachment 4.19-B. In addition, all of the milestones contained in the CMS-approved "California SPA 05-023 MILESTONES DOCUMENT" must be met to ensure Federal financial participation.

Eligible professional costs are reported on the designated hospitals' Medi-Cal 2552 cost report and, in the case of the University of California (UC) hospitals, the UC School of Medicine physician/non-physician practitioner cost report as approved by the Centers for Medicare & Medicaid Services.

A. General Reimbursement Requirements

1. The government-operated hospitals identified in Section B on page 53 of this attachment, and the government operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, are eligible providers that will receive supplemental payments for the un-reimbursed Medicaid costs specified in Section C on page 53 of this attachment, below.

2. Eligible providers will receive Medi-Cal fee-schedule payments for professional services. In addition, the eligible providers will receive supplemental payments up to cost as specified in Section C on page 53 of this attachment. The reimbursement under this segment of Attachment 4.19-B is available only for Medicaid costs that are in excess of Medicaid fee schedule payments.

3. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid services described in this segment of Attachment 4.19-B, that are provided to Medi-Cal patients by physicians and non-physician practitioners of government-operated hospitals or the government entities with which they are affiliated, will be governed by this segment of Attachment 4.19-B.

4. Professional costs incurred by freestanding clinics that are not recognized as hospital outpatient departments on the 2552 and are reimbursable as clinic costs pursuant to TN 06-16 are not included in this protocol. Professional costs incurred at clinics that operate on the hospital's license under state licensing laws will be included under this segment of Attachment 4.19-B to the extent they are not reimbursable as clinic costs pursuant to TN 06-16. The physician office settings owned and operated by the UC Schools of Medicine are not considered freestanding clinics.

5. The supplemental payments determined under this segment of Attachment 4.19-B will be paid on a quarterly basis.

B. Eligible Providers

1. The physician and non-physician practitioner professional costs being addressed in this protocol are limited to professional costs incurred by the governmental hospitals listed below, including any successor or differently named hospital, as applicable, and their affiliated government physician practice groups (i.e., practice group that is owned and operated by the same government entity that owns and operates the hospital). These professional costs are reported on the designated hospitals' Medi-Cal 2552 cost report and, in the case of the University of California (UC) hospitals, the UC School of Medicine physician/non-physician practitioner cost report as approved by CMS.

Government-Operated Hospitals:

Alameda County Medical Center
Alameda Hospital (DPH date July 1, 2016)
Arrowhead Regional Medical Center
Contra Costa Regional Medical Center
Kern Medical Center
Natividad Medical Center
Riverside University Health System – Medical Center
San Francisco General Hospital
San Joaquin General Hospital
San Leandro Hospital (DPH date July 1, 2016)
San Mateo County General Hospital
Santa Clara Valley Medical Center
Tuolumne General Hospital (Closed June, 2007)
Ventura County Medical Center

Los Angeles County (LA Co.) Hospitals:

LA Co. Harbor/UCLA Medical Center
LA Co. Martin Luther King Jr./Drew Medical Center (Closed August, 2007)

LA Co. Olive View Medical Center
LA Co. Rancho Los Amigos National Rehabilitation Center
LA Co. University of Southern California Medical Center

State Government-Operated University of California (UC) Hospitals:

UC Davis Medical Center
UC Irvine Medical Center
UC San Diego Medical Center
UC San Francisco Medical Center
UC Los Angeles Medical Center
Santa Monica UCLA Medical Center (aka – Santa Monica UCLA Medical Center & Orthopedic Hospital)

C. Reimbursement Methodology

This interim supplemental payment will approximate the difference between the fee-for-service (FFS) payment and the allowable Medicaid costs related to the professional component of physician or non-physician practitioner services eligible for Federal financial participation. This computation of establishing the interim Medicaid supplemental payments must be performed on an annual basis and in a manner consistent with the instructions below.

1. Non-UC Provider Steps

a. The professional component of physician costs are identified from each hospital's most recently filed Medi-Cal 2552 cost report Worksheet A-8-2, Column 4. These professional costs are:

1. limited to allowable and auditable physician compensations that have been incurred by the hospital;
2. for the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service, including sites that are not owned or operated by an affiliated government entity;
3. identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment (or, for registry physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the registry physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities)

administrative, teaching, research, or any other provider component or non-patient care activities)

4. supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above)
5. removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 (or Worksheet A-8 for registry physicians) are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for Medicaid physician professional cost determination purposes. There will be revenue offsets to account for revenues received for services furnished by such professionals to non-patients (patients whom the hospital does not directly bill for) and any other applicable non-patient care revenues that were not previously offset or accounted for by the application of time study.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the Medi-Cal cost report. The practitioner types to be included are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medi-Cal cost report, these costs may be recognized if they meet the following criteria:

1. the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medi-Cal separate from hospital services;
2. for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
3. a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs;

4. the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the hospital does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

   The resulting net clinical non-physician practitioner compensation costs are allowable costs for this section of Attachment 4.19-B. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are separately reimbursable as clinic costs and therefore should not be included in this protocol, except that, until the effective date of TN 06-16, professional costs incurred at clinics that operate on the hospital's license under state licensing laws will be included under this segment of Attachment 4.19-B.

f. Hospitals may additionally include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that :

   1. these costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
   2. they are directly identified on ws A-8 as adjustments to hospital costs;
   3. they are otherwise allowable and auditable provider costs; and
   4. they are further adjusted for any non-patient-care activities such as research based on physician time studies.

   If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed for the purposes of this section of 4.19-B.

g. Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from hospital records. Los Angeles County hospitals, due to their all-inclusive billing limitations, do not have itemized physician or non-physician practitioner charges. Therefore, these hospitals are to use the hospital RVU system to apportion professional costs to

Medicaid; this is the same RVU system as that used by Los Angeles County hospitals for Medicare and Medi-Cal cost reporting purposes. Where charges are mentioned in this paragraph and later paragraphs in this subsection, Los Angeles County will use its RVUs. References below to charges identified by the State's MMIS/claims system are not applicable to Los Angeles County hospitals.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 1 by the total billed professional charges for each cost center as established in paragraph g of subsection 1 .For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f of subsection 1 by the total billed professional charges for each practitioner type as established in paragraph g of subsection 1.

i The total professional charges for each cost center related to covered Medi-Cal FFS physician services, billed directly by the hospital, are identified using paid claims data from the State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and does not track claims on a cost center basis, hospitals must map the claims to their cost centers using information from their hospital billing systems. Each charge may only be mapped to one cost center to prevent duplicate mapping and claiming. These charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the covered Medicaid FFS professional charges, billed directly by the hospital, are identified using paid claims data from State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and may not track claims by non-physician practitioner type, hospitals must map the charges to non-physician practitioner type using information from their hospital billing systems. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

The State will allow hospitals to bill Medi-Cal for those physician services that previously were covered under the all-inclusive hospital rates retroactive to 2005-06 in order to generate the charges for these services in the MMIS/claims system that can be used to determine the reimbursable professional services costs.

j. The total Medicaid costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid FFS charges as established in paragraph i of subsection 1 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 1.

For each non-physician practitioner type, the total Medicaid costs related to non-physician practitioner professional services are determined by multiplying total Medicaid FFS charges as established in paragraph i of subsection 1 by the respective cost to charge ratios as established in paragraph h of subsection 1.

k. The total Medicaid costs eligible for Medicaid supplemental payment are determined by subtracting all Medicaid FFS physician/practitioner payments received from the Medicaid FFS costs as established in paragraph j of subsection 1. The amount of the Medicaid interim supplemental payment will be based on the Medicaid fee schedule payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS/claims system and auditable provider records. All revenues received (other than the Medicaid physician supplemental payments being computed here in this section) for the Medicaid professional services will be offset against the computed cost; these revenues include payments from the State, patient co-payments, and payments from other payers.

l. The Medicaid physician/practitioner amount computed in paragraph k of subsection 1 above can be trended to current year based on Market Basket update factor(s) or other medical care-related indices as approved by CMS. The Medicaid amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1). Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.

(2). Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the hospital and subject to review by the State and CMS. The result is the Medicaid physician/practitioner amount to be used for interim Medicaid supplemental payment purposes.

2. UC Provider Steps

a. The physician compensation costs are identified from each UC School of Medicine's trial balance and reported on a CMS-approved UC physician/practitioner cost report. These professional compensation costs are limited to identifiable and auditable costs that have been incurred by the UC School of Medicines' physician practice group(s) for the professional patient care

furnished in all applicable sites of service, including services rendered at non-hospital physician office sites operated by the UC practice groups and at sites not owned or operated by the UC for which the UC practice group bills for and collects payment.

The physician compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

b. On the UC physician cost report, these physician compensation costs net of NIH grants as applicable, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study. Prior to July 1, 2008, the UCs may use a CMS-approved benchmark RVU methodology in lieu of the CMS-approved time study to allocate UC physician compensation costs between clinical and non-clinical activities only. The result of the CMS-approved time study (or the benchmark RVU methodology before July 1, 2008) is the physician compensation costs pertaining only to clinical, patient care activities.

c. The physician clinical costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for Medicaid professional cost determination purposes. There will be offset of revenues received for services furnished by such professionals to non-patients (patients for whom the UC does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

d. Reimbursement for non-physician practitioner compensation costs will also be included. The practitioner types to be included on the UC physician/practitioner cost reports are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

e. These non-physician practitioner compensation costs are recognized if they meet the following criteria:

(1) the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medi-Cal separate from hospital services;
(2) the non-physician practitioner compensation costs are derived from an identifiable and auditable data source by practitioner type;
(3) a CMS approved time study will be employed to allocate practitioner compensation between clinical and non-clinical costs;
(4) the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the UC does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs under this section of Attachment 4.19-B. Each non-physician practitioner type is reported in its own cost center on the UC physician/practitioner cost report.

f. The above physician or non-physician practitioner compensation costs must not be duplicative of any costs claimed on the UC hospital cost reports.

g. Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipments used in the furnishing of direct patient care.

h. Overhead costs will be recognized through the application of each UC's cognizant agency-approved rate for indirect costs. The indirect rate will be applied to the total direct cost, calculated above, based on each center/department's physician and/or non-physician practitioner compensation costs determined to be eligible for Medicaid reimbursement and identifiable medical supply/equipment costs to arrive at total allowable costs for each cost center.

Other than the direct costs defined above and the application of an approved indirect rate, no other costs are allowed for the purpose of this section of 4.19-B.

i. Total billed professional charges by cost center related to physician services are identified from provider records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from provider records.

j. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-h of subsection 2 by the total billed professional charges for each cost center as established in paragraph i of subsection 2. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-h of subsection 2 by the total billed professional charges for each practitioner type as established in paragraph i of subsection 2.

k. The total professional charges for each cost center related to covered Medi-Cal FFS physician services, billed directly by UC, are identified using paid claims data from the State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and does not track claims on a cost center basis, UCs must map the claims to their cost centers using information from their billing systems. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the covered Medicaid FFS professional charges, billed directly by the UC, are identified using paid claims data from State's MMIS/claims system. Because the MMIS/claims system is based on CPT codes and may not track claims by non-physician practitioner type, UCs must map the claims to non-physician practitioner type using information from their billing systems. Each charge must only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

The State will allow the UCs to bill Medi-Cal for those physician services that previously were covered under the all-inclusive hospital rates retroactive to 2005-06 in order to generate the charges for these services in the MMIS/claims system that can be used to determine the reimbursable professional services costs.

l. The total Medicaid costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid FFS charges as established in paragraph k of subsection 2 by the respective cost to charge ratio for the cost center as established in paragraph j of subsection 2.

For each non-physician practitioner type, the total Medicaid costs related to non-physician practitioner professional services are determined by multiplying total Medicaid FFS charges as established in paragraph k of subsection 2 by the respective cost to charge ratios as established in paragraph j of subsection 2.

m. The total Medicaid costs eligible for Medicaid supplemental payment are determined by subtracting all Medicaid FFS physician/practitioner payments

received from the Medicaid FFS costs as established in paragraph l of subsection 2. The amount of the Medicaid interim supplemental payment will be based on the Medicaid fee schedule payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS/claims system and auditable provider records. All revenues received (other than the Medicaid physician supplemental payments being computed here in this section) for the Medicaid professional services will be offset against the computed cost; these revenues include payments from the State, patient co-payments, and payments from other payers..

n. The Medicaid physician/practitioner amount computed in paragraph m above can be trended to current year based on Market Basket update factor(s) or other medical care-related indices as approved by CMS. The Medicaid amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1) Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.

(2) Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the UCs and subject to review by the State and CMS. The result is the Medicaid physician/practitioner amount to be used for interim Medicaid supplemental payment purposes

D. Interim Reconciliation

The physician and non-physician practitioner interim supplemental payments determined under Section C on page 53 of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed Medi-Cal 2552 and UC physician/practitioner cost reports for the same year once the cost reports have been filed with the State. The UC physician/practitioner cost report should be filed, reviewed, and finalized by the State in a manner and timeframe consistent with the Medi-Cal hospital cost report process. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, the provider will receive an adjusted payment amount. For purposes of this reconciliation the same steps as outlined for the interim payment method are carried out except as noted below:

1. For the determinations made under paragraphs a through h of subsection 1 and paragraphs a through j of subsection 2 of Section C, the costs and charges from the as-filed physician/practitioner cost report for the expenditure year are used.

2. For the determinations made under paragraph i of subsection 1 of Section C and paragraph k of subsection 2 of Section C, Medicaid fee-for-service professional charges for covered services furnished during the applicable fiscal year are used. The State will perform those tests necessary to determine the reasonableness of the Medi-Cal program physician charges from the as-filed physician/practitioner cost report. This will include reviewing the Medicaid program data generated from its MMIS/claims system for that period which corresponds to the most recently filed physician/practitioner cost report. However, because the MMIS/claims system data would generally not include all paid claims until at least 18 months after the Fiscal Year Ending (FYE) of the cost report, the State will take steps to verify the filed Medicaid program data, including the use of submitted Medicaid claims. Only Medicaid program data related to medical services that are eligible under the Medicaid physician/practitioner cost computation should be used in the apportionment process.

3. For the determinations made under paragraph k of subsection 1 of Section C and paragraph m of subsection 2 of Section C, Medicaid fee-for-service payments for professional services furnished during the applicable state fiscal year from the State's MMIS/claims system are used. However, if MMIS charges are adjusted in subsection 2 above, Medicaid fee-for-service payment offsets will also need to be adjusted accordingly.

E. Final Reconciliation

Once the Medi-Cal 2552 and the UC physician/practitioner cost report for the expenditure year have been finalized by the State, a reconciliation of the finalized costs to all Medicaid payments made for the same period will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized Medi-Cal 2552 and UC physician/practitioner cost amounts and updated Medicaid data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

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

REIMBURSEMENT FOR ADULT DAY HEALTH CARE CENTERS

(1) Reimbursement for services provided in an Adult Day Health Care (ADHC) Center shall be equal to 90 percent of the rate established for Nursing Facilities – Level A for the corresponding rate year, pursuant to the methodology described in Attachment 4.19-D, beginning on page 10.

(2) For dates of service on or after March 1, 2009, through and including March 8, 2009, payments for services provided in an ADHC Center shall be the rate as calculated in paragraph (1), less 5 percent

(3) For dates of service March 1, 2011, through and including May 31, 2011, payments for services provided in ADHC Centers located within specified Medical Service Study Areas (MSSAs) in Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz and Ventura counties shall be the rate as calculated in paragraph (1), less 5 percent.

MSSAs are the defined geographic analysis unit for the California Office of Statewide Health Planning and Development (OSHPD). They are composed of one or more complete U.S. Census Bureau census tracts and are reproduced on the decadal census. The boundaries are approved by the Health Manpower Policy Commission and the U.S. Department of Health and Human Services, Health Resources Service and Administration (HRSA), formally recognizes California MSSAs as the Rational Service Area for medical service for California. MSSAs are published on the OSHPD website at: http://www.oshpd.ca.gov/General_Info/MSSA/AtoC.html.

(4) For dates of service June 1, 2011, through and including March 31, 2012, payments for services provided in ADHC Centers located within specified Medical Service Study Areas (MSSAs) in Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz and Ventura counties shall be the rate as calculated in paragraph (1), less 10 percent.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

REIMBURSEMENT FOR ALTERNATIVE BIRTH CENTERS AND LICENSED OR OTHERWISE STATE-RECOGNIZED COVERED PROFESSIONALS PROVIDING SERVICES IN THE ALTERNATIVE BIRTH CENTER

Alternative Birth Center services described in paragraph 29.a of Attachment 3.1-A and in paragraph 28.a of Attachment 3.1-B of the California State Plan are reimbursed at the lower of (1) the usual and customary rate, or (2) California Department of Health Care Services' (DHCS') published statewide all-inclusive rate per delivery.

DHCS' fee schedule will be set as of July 1, 2014, and is effective for services provided on or after that date. The DHCS rates are published on the DHCS Website at http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp.

The all-inclusive reimbursement rate is updated annually and is based on the annual published legislative report of average contract rate for general acute care hospitals with Medi-Cal contracts.

Reimbursement rates for licensed or otherwise State-recognized covered professionals providing services in an Alternative Birth Center as described in paragraph 29.b of Attachment 3.1-A and in paragraph 28.b of Attachment 3.1-B are published on the DHCS Website referenced above.

Except as otherwise provided in the State Plan, State developed fee schedule rates are the same for both governmental and private providers of Alternative Birth Center services.